EFFECTIVENESS OF LIFE SKILL EDUCATION PACKAGE UPON KNOWLEDGE AND ATTITUDE ON HIV AMONG ADOLESCENTS IN SELECTED SETTING, KANYAKUMARI DISTRICT.

DISSERTATION SUBMITTED TO
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IN PARTIAL FULFILMENT OF THE REQUIREMENT FOR
THE DEGREE OF MASTER OF SCIENCE IN NURSING
CHILD HEALTH NURSING
APRIL 2014

CERTIFICATE

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ABSTRACT

A Quasi experimental study to evaluate the effectiveness of Life skill education package upon knowledge and attitude on HIV among adolescents in selected settings , kanyakumari district

The design adopted was Quasi experimental pretest post test control group design. Setting of the study was The Salvation Army Community Health and Development programme, Catherine booth hospital, Nagercoil. The sample size was 60 and drawn through purposive sampling technique. Pre test was conducted to assess the level of knowledge and attitude. Life skill education package was given for the study group. Post test was done on the seventh day after the pretest during data collection. The data gathered were analyzed by descriptive and inferential statistical method and interpretations were made on the basis of the objectives of the study.

Regarding the knowledge, in Study group, during the pre test, 22 (73.3%) had adequate knowledge, 8 (26.67%) had moderate level of knowledge , and none of them had adequate knowledge. In control group during the pre test 28 (93.3%) had poor knowledge, 2 (6.67%) had moderate level of knowledge, and none of them had poor knowledge. Regarding the attitude ,in control group , during the pre test 4 (13.33%) had positive attitude, 21 (70%) had neutral attitude, 5 (16.67%) had negative attitude. In Study group during the pre test 27 (90%) had neutral attitude, 3 (10%) had negative attitude , and none of them 0 (0%) had positive attitude.

Regarding the knowledge in study group, during the post test ,30 (100%) had adequate knowledge, 0 (0%) had moderate level of knowledge , 0 (0%) had poor knowledge. In Control group , 8 (26.7%) had moderate level of knowledge,22 (73.3%) had poor knowledge, 5(16.7) and none of them had adequate knowledge. Regarding the attitude in study group during the post test, 21 (70%) had positive attitude, 9 (30%) had

neutral attitude , 0 (0%) had negative attitude. In Control group , 15 (50%) had neutral attitude ,15 (50%) had negative attitude, 0(0%) and none of them had positive attitude.

While comparing the post test level of knowledge in Study and control group the mean value of knowledge in study group was 13.5 and in control group was 4.13. The estimated 't' value was 27.56 which is significant at $p< 0.05$. It shows that Life skill education package was effective in improving the knowledge among HIV affected adolescents. While comparing the post test level of attitude in Study and control group the mean value of attitude in study group was 73.5 and in control group the mean value was 36.16. The estimated 't' value was 26 which is significant at $p< 0.05$. It shows that life skill education package was effective in improving the attitude. There is no significant association between the level of knowledge and attitude of HIV among HIV affected adolescents with their selected demographic variables in Study group and Control group .

CHAPTER -I

INTRODUCTION

Adolescence is a period of transition between childhood and adulthood. The word ‘adolescent’ is derived from Latin word “adolescere” meaning ‘‘to grow up’’. Adolescence is the phase, usually between 13-18 years, in which children undergo rapid changes in body size, physiology and psychological and social functioning. During this period, all body dimensions, development and maturation are completed. During adolescence, young people go through many changes as they move from childhood into physical maturity. Early prepubescent changes occur when the secondary sexual characteristics appear. Many sample do die prematurely due to accidents, suicide, violence, pregnancy related complications and other illnesses that are either preventable or treatable. Many more suffer chronic ill-health and disability. In addition, many serious diseases in adulthood have their roots in adolescence. For example, tobacco use, sexually transmitted infections including HIV, poor eating and exercise habits, lead to illness or premature death later in life.

Acquired immuno deficiency syndrome (AIDS) is a disease of human immune system caused by HIV, the condition progressively reduces the effectiveness of immune system and leaves the individuals susceptible to opportunistic infections and tumors. Although the progress has been made in treating the HIV infection and AIDS, the epidemic remains a critical public issue in all the communities across the country and around the world. Prevention, early detection and ongoing treatment remain important aspects of the care for the people with HIV infection and AIDS.

Since AIDS was first recognized more than 20years of age, remarkable progress has been made in improving the quality and duration of life for the people with HIV infection. During the first decade this progress was associated with the recognition of the opportunistic disease process more effective therapies for the complications and the introduction of the prophylaxis against the common opportunistic infections. The second

decade witnessed the progress in the development of Highly Active Anti Retroviral Therapies as well as continuing in the treatment of opportunistic infection. The third decade has focused on the issues of adherence to the therapy development of the second generation medication to treat HIV infection and continued pressure to develop a vaccine

50% of all new HIV infections occur in young people under the age of 25, with an estimated 20,000 or more young people infected annually. In 2008 American Association of World Health reported that, approximately 50 percent of all high school students in grades nine to twelve have had sexual intercourse; almost 25 percent of all twelveth graders have had four or more partners. About one-half of these same twelveth graders reported using a latex condom during intercourse.

According to a study by the American Federation of AIDS Research 2001, the sexual behaviour of young people is highly influenced by the use of alcohol and drugs, which decreases decision-making skills and has a negative effect on behaviour. This study found that an estimated 3 million teenagers were alcoholics. Several million more had a drinking problem that they could not handle on their own. A separate study showed that in high school youths, steroid was a problem among athletes of both genders. Steroid use, including injecting steroids, occurs more often among young people who are involved in physical training because anabolic steroids increase muscle mass, strength, and stamina .The fact that steroids can be injected intravenously places users at risk for contracting HIV/AIDS and hepatitis C. The study also reported that at least half of all reported HIV infections among males aged 13 through 24 occurred among young men who have sex with men.

In October 2013, The World Health Organization reported that HIV continues to be a major global public health issue, having claimed more than 36 million lives so far. There were approximately 35.3 million people living with HIV in 2012. Sub Saharan Africa is the most affected region, with nearly 1 in every 20 adults living with HIV. 69% of all people living with HIV are living in this region. HIV infection is usually diagnosed through blood tests detecting the presence or absence of HIV antibodies. There is no cure for HIV infection. However, effective treatment with antiretroviral drugs can control the virus so that people with HIV can enjoy healthy and

productive lives. In 2012, more than 9.7 million people living with HIV were receiving antiretroviral therapy (ART) in low- and middle-income countries.

Background of the study

HIV/AIDS is a global pandemic. Since AIDS was first recognized in 1981 and 2009 it has led to nearly 30 million deaths.

In 2012, an estimated that 35.3 million people globally were living with HIV, 2.3 million people became newly infected with HIV & 1.6 million people died from AIDS-related illnesses. New HIV infections among adults and children were estimated at 2.3 million in 2012, a 33% reduction since 2001. New HIV infections among children have been reduced to 2,60, 000 in 2012, a reduction of 52% since 2001.

In 2011 Joint United Nations Programme on AIDS reported that HIV has impacted every region of the world in just 40 years and thirty-four million people are living with HIV worldwide

As of 2011 approximately 34 million people have HIV worldwide. Of these, approximately 17.2 million are men, 16.8 million are women and 3.4 million are less than 15 years old. There were about 1.8 million deaths from AIDS in 2010, down from 2.2 million in 2005.

In 2008 approximately 1.2 million people in the United States had HIV; 20% did not realize that they were infected. In Canada as of 2008 there were about 65,000 cases and 53 deaths. It resulted in about 17,500 deaths. In the United Kingdom, as of 2009, there were approximately 86,500 cases and 516 deaths. In Australia, as of 2009, there were about 21,171 cases and around 23 deaths.

Sub Saharan Africa is the region most affected. In 2010, an estimated 68% (22.9 million) of all HIV cases and 66% of all deaths (1.2 million) occurred in this region. This means that about 5% of the adult populations is infected. Here in contrast to other regions women compose nearly 60% of cases. South Africa has the largest population of people with HIV of any country in the world at 5.9 million.

In developing countries alone approximately 15 million people are living with HIV. The percentage of young adults in these nations who are able to correctly identify facts about HIV transmission is 34% (UNAIDS , 2010). Today, thirty three developing countries have decreased HIV incidence rates by 25% **(**UNAIDS, 2010). Of the 15 million people living with HIV (PLWHA) in these countries, over 6 million are receiving anti-retroviral therapy (UNAIDS, 2011).

South & South East Asia a region with about 2 billion people as of 2010, over 30% of the global population has an estimated 4 million cases 12% of all people living with HIV, with about 250,000 deaths in 2010. Approximately 2.5 million of these cases are in India, where however the prevalence is only about 0.3% somewhat higher than that found in Western and Central Europe or Canada. Prevalence is lowest in East Asia at 0.1%.

In 2011 ,World Health Organization stated that**,** despite impressive gains in curtailing the epidemic, the prevalence of HIV in developing countries continues to be a matter of concern. In 2008, developing countries spent over $13.7 billion on antiretroviral therapy, which, for many nations resulted in spending over 50% of domestic expenditures on battling the HIV epidemic (Sidibe, 2011). Among 2 developing countries with a total of 131,000 testing facilities, the median number of HIV tests conducted per 1,000 adults was 47 in 2009 and 55 in 2010. Today, there are 1.6 billion people aged 12-24–the largest generation of sample and young people ever. In 2010 young people aged 15–24 accounted for 42% of new HIV infections in people aged 15 and older. Among young people living with HIV, nearly 80% (4 million) live in sub-Saharan Africa. Globally, young women aged 15-24, have HIV infection rates twice as high as in young men, and account for 22% of all new HIV infections and 31% of new infections in Sub-saharan Africa.

Though rate of HIV transmission in Asia is slowing down, at least 1,000 new infections among adults continue to be reported in the continent every day in 2011. An estimated 360,000 adults were newly infected with HIV in Asia in 2011, considerably fewer than 440,000 estimated for 2001, a new UNAIDS report has said. It also said a total 1.7 million people had died across the world due to AIDS related illness. In India, the figure for such deaths stood at 170,000 in 2009. The report says India has contributed enormously to the AIDS response.

The last decade has seen a 50% decline in the number of new HIV infections. According to more recent National AIDS Control Organisation data, India has demonstrated an overall reduction of 57 percent in estimated annual new HIV infections (among adult population) from 0.274 million in 2000 to 0.116 million in 2011, and the estimated number of people living with HIV was 2.08 million in 2011.

While the National AIDS Control Organisation 2008**,** estimated that 2.39 million people live with HIV/AIDS in India in 2008-09, and a more recent investigation by the Million Death Study Collaborators in the British Medical Journal (2010) estimates the population to be between 1.4 - 1.6 million people.

The estimated adult HIV prevalence was 0.32% in 2008 and 0.31% in 2009. The states with high HIV prevalence rates include Manipur (1.40%), Andhra Pradesh (0.90%), Mizoram (0.81%), Nagaland (0.78%), Karnataka (0.63%) and Maharashtra (0.55%). Though rate of HIV transmission in Asia is slowing down, at least 1,000 new infections among adults continue to be reported in the continent every day in 2011.

An estimated 360,000 adults were newly infected with HIV in Asia in 2011, considerably fewer than 440,000 estimated for 2001, a new UNAIDS report has said . In 2011, another one report of United nations programme on AIDS says that there are 2,439 Pediatric cases in 2010.

Significance and need for the study

Although progress has been made in treating HIV infection and AIDS, the epidemic remains a critical public health issue in all communities across and around the world. Prevention, early education, and ongoing treatment remain important aspects of care for people with HIV Infection and AIDS.

World wide AIDS kills more than 8,000 people everyday, one person every seconds (UNAIDS). Now a days as a result of modernization and urbanization the HIV infection is spreading widely, and now the sample is a risk group for getting the infection due to their ignorance and carelessness

India is one of the largest and most populated countries in the world, with over the billion inhabitants. Of this number, it is estimated that around 2.3 million people are

currently living with HIV. In 25 November 2013 World Health Organization report says that more than 2 million sample between the ages of 10 and 19 years are living with HIV, and many do not receive the care and support that they need to stay in good health and prevent transmission. In addition, millions more sample are at risk of infection. The failure to support effective and acceptable HIV services for sample has resulted in a 50% increase in reported AIDS-related deaths in this group compared with the 30% decline seen in the general population from 2005 to 2012. So the specific needs of sample should be met for both for those living with HIV and those who are at risk of infection.

One of the important problem in the community is HIV infection. Despite adequate knowledge about HIV/AIDS among the sample , misconceptions about routes of transmission were found. Negative attitudes to HIV and risky practices were also present. Educational programmes with specific interventions are recommended to increase the knowledge attitude and to prevent new HIV infections.

Life skill education have been defined by the (World Health Organization , 2009) as "abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life". They are a set of human skills acquired via teaching or direct experience that are used to handle problems and questions commonly encountered in daily human life. They represent the psycho-social skills that determine valued behaviour and include reflective skills such as problem-solving and critical thinking, to personal skills such as self-awareness, and to interpersonal skills. Practicing life skills leads to qualities such as self-esteem, sociability and tolerance, to action competencies to take action and generate change, and to capabilities to have the freedom to decide what to do and who to be.

Life skills-based education is now recognized as a methodology to address a variety of issues of child and youth development and thematic responses including as expressed in UNITED NATIONS GENERAL ASSEMBLY SPECIAL SESSION (UNGASS) on HIV/AIDS (2001), UNGASS on Children (2002), World Youth Report (2003), World Program for Human Rights Education (2004), UN Decade on Education for Sustainable Development (2005), UN Secretary General's Study on Violence Against Children (2006), 51st Commission on the Status of Women (2007), and the World Development Report (2007).

Expected learning outcomes include a combination of knowledge, values, attitudes and skills with a particular emphasis on those skills that related to critical thinking and problem solving, self-management and communication and inter-personal skills.

Adolescents are more vulnerable to get HIV infection due to peer group influence. So they will have the habit of alcoholism, drug addiction, homosexual activities etc. Through the mass media also they are getting information regarding HIV infection. Even the incidence rate is higher among adolescents. They were not aware of the consequences. Even the adolescents living with HIV does not having adequate knowledge regarding aids. They think that they have got a disease which none of the people will get. And also they will withdraw themselves from the society. So Life skill education is very essential to understand about the disease and to change the attitude . So that they can also think that they can live like other persons and adopt various skills in the society.

Shah .I(2011) conducted a study on Prevalence of orphans among HIV infected children-a preliminary study from a pediatric HIV centre in Western India. The results were Fifty nine (40%) HIV-infected children were orphans. In 28 children (19%), father had died: in 20 children (13.6%), mother had died; in 11 children (7.5%) both parents had died and in 2 children (1.4%), parents death status was not known. Cause of death was AIDS in 19 parents (38%) and TB in 21 parents (42%).

HIV is also like other communicable disease. It can't be treated, but it can be prevented. The investigator personally had an experience with a women who got affected with HIV , who was a mother of three female child. She acquired HIV infection from her husband. The husband's family members were aware of the infection and they have a myth that this will be cured if he gets married. And now the whole family including the two daughters were infected. The husband died. Like this in our society many of them acquire HIV infection due to lack of awareness. So creating awareness is an important aspect in preventing such kind of infections. And when the awareness is given in the adolescent stage, it will be more effective than the other age group. So the investigator thought of creating awareness to the adolescents regarding HIV.

Statement of the problem

An experimental study to evaluate the effectiveness of Life skill education package upon knowledge and attitude of HIV among adolescents in selected settings , kanyakumari district.

Objectives of the study

- To compare the pre test and post test level of knowledge and attitude among adolescents with HIV in study group and control group
- To evaluate the effectiveness of Life skill education package on knowledge and attitude of adolescents with HIV in study group and control group.
- To find out the association between the post test level of knowledge and attitude among adolescents with HIV in study and control group with the demographic variables.

Research hypotheses

H_1. There is significant difference between the pre test and post test level of knowledge and attitude among adolescents with HIV in study group and control group.

H2. There is significant difference between the post test level of knowledge and attitude among adolescents with HIV in study group and control group .

H_3. There is significant association between post test level of knowledge and attitude among adolescents with HIV in the selected demographic variables.

Assumptions

- The adolescents may have less knowledge and have negative attitude on HIV.
- Life skill education package may help to improve the knowledge and attitude of adolescents.

Operational definitions

1. **Evaluate**

Evaluation refers to the identification of difference between pre test and post test level of knowledge and attitude and finding the effectiveness of life skill education package among adolescents.

2. **Effectiveness**

It is the modification in the level of knowledge and attitude after the implementation of life skill education package by using knowledge questionnaire and attitude rating scale.

3. Life skill education package

It is an educational strategy used to create awareness on AIDS. It includes various activities which are divided into various sections such as role play , power point presentation, chart , and pamphlets. Each session is given for 30 minutes on the first and the second week of Saturday for the study group.

4. Knowledge

It is the awareness of HIV/AIDS through Life skill education package among adolescents with HIV.

5. Attitude

It is a positive or negative evaluation of HIV among adolescents affected with HIV

6. Adolescents

It refers to the age group between 13 to 18 years of Boys and Girls with HIV.

Delimitations

The study was delimited to,

- Four weeks period for data collection.
- Only selected adolescents with HIV.
- Sample size: 30 in study group and 30 in control group.

Projected outcome

The study will help to improve the knowledge and attitude of HIV through Life skill education package, among adolescents with HIV.

CONCEPTUAL FRAMEWORK

The conceptual framework based on Imogene King's Goal Attainment Theory(1981) consists of personal & interpersonal systems including interaction, perception, judgment, communication and transaction. This involved interaction between the investigator and the HIV affected adolescents.

Six major concepts described the following:

Perception

It refers to people's representation of reality. Here the investigator and the HIV affected adolescents perceived the need of improving the knowledge and attitude of HIV .

Judgment

Judgment is decision which is made. After perception , here the investigator decided to provide Life skill education to improve the knowledge and attitude among HIV affected adolescents who decided to participate in the research study . Then pre test was done for them.

Action

This refers to the changes that have to be achieved. The investigator's action was to provide life skill education package to improve the knowledge and attitude of HIV among adolescents with HIV , and to identify the effectiveness of life skill education package

Reaction

Reaction helps in setting a mutual goal. In this study the investigator and HIV affected adolescents set a mutual goal to improve the knowledge and attitude towards HIV in day to day life .

Interaction

If refers to the verbal and non verbal communication between one individual or between two or more individual who involve goal directed perception. Here the investigator encouraged the adolescents to share and clarify their doubts among themselves and monitored the level of knowledge and attitude.

Transaction

This was the achievement of a goal. Here the investigator's goal was Improvement in the knowledge and attitude of HIV through life skill education package. It was evaluated with the post test to find the effectiveness.

Impact of King's goal attainment theory:

Imogene King's goal attainment theory was utilized for this study. The investigator selected HIV affected adolescents for this study. Both the participants and the investigator decided to participate in this study. Decisions made to provide education for the study participants. Life skill education package was given regarding the knowledge and attitude of HIV and the effectiveness was evaluated by the post test. There is a improvement in the study group and no improvement in the control group .

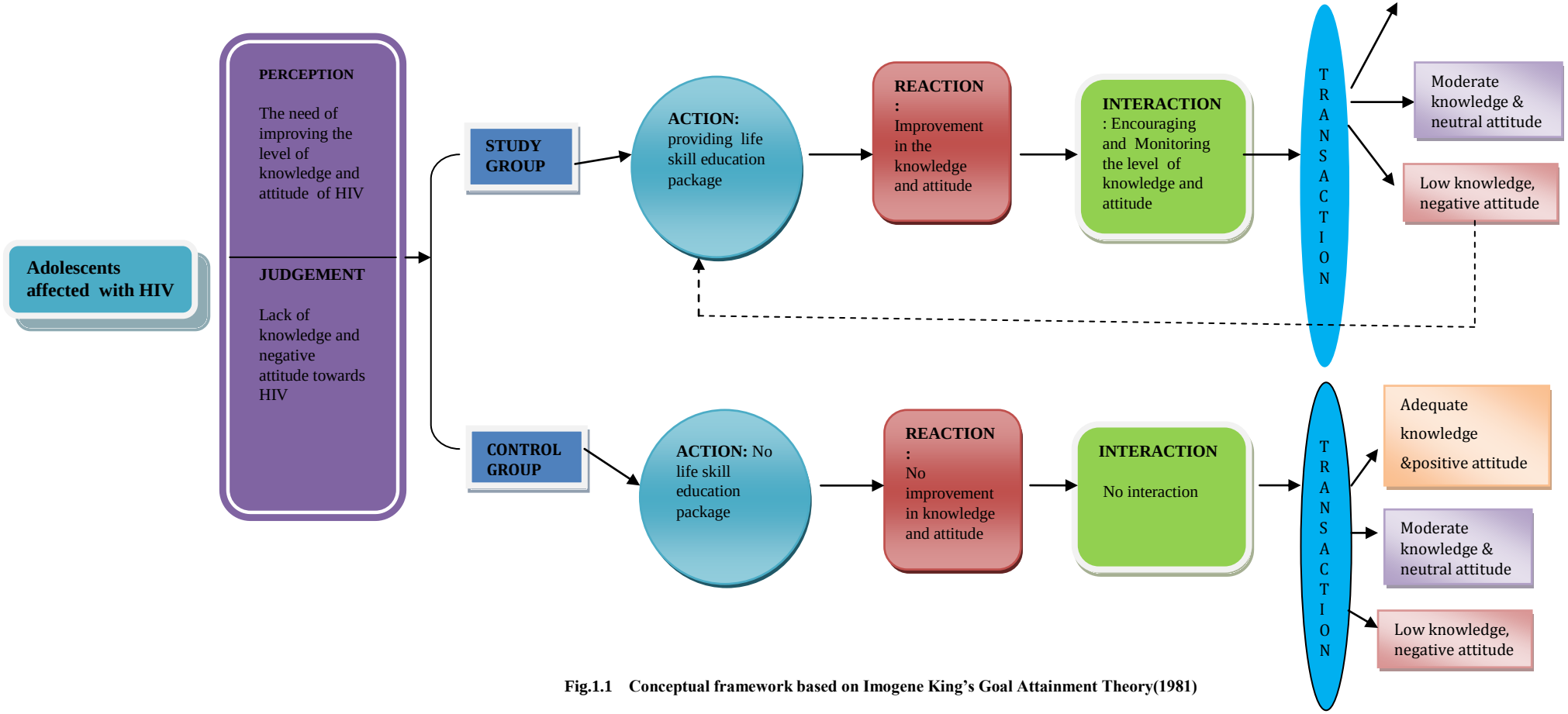


Fig.1.1 Conceptual framework based on Imogene King's Goal Attainment Theory(1981)

CHAPTER –II

REVIEW OF LITERATURE

Investigators never conduct a study in an intellectual vacuum; their studies are actually undertaken within the context of an existing knowledge base. Review of literature is an important step in the development of a research project.

Review of literature is defined as the process of reading, analyzing, evaluating, and summarizing scholarly materials about a specific topic. The results of a literature review may be compiled in a report or they may serve as part of a research article, thesis, or grant proposal.

Review of literature of the present study was arranged in the following headings:

Section A : Studies related to HIV/AIDS.
Section B : Studies related to Knowledge and attitude of adolescents on HIV
Section C : Studies related to Knowledge and attitude of People living with HIV regarding HIV /Aids

Section A : Studies related to HIV/AIDS

Shah .I(2011) conducted a study on Prevalence of orphans among HIV infected children-a preliminary study from a pediatric HIV centre in Western India. The results were Fifty nine (40%) HIV-infected children were orphans. In 28 children (19%), father had died: in 20 children (13.6%), mother had died; in 11 children (7.5%) both parents had died and in 2 children (1.4%), parents death status was not known. Cause of death was AIDS in 19 parents (38%) and TB in 21 parents (42%).

Connolly *et al* (2010), conducted a study on the effects of circumcision on HIV in South Africa. The study revealed that, among racial groups, "circumcised Blacks showed similar rates of HIV as uncircumcised Blacks, (OR: 0.8, p = 0.4) however other racial

groups showed a strong protective effect, (OR: 0.3, p = 0.0) .When the data are further stratified by age of circumcision, there is a slight protective effect between early circumcision and HIV among Blacks. It was concluded that in general, circumcision offers slight protection in the transmission of HIV.

Bryan. A.D,et al (2009)conducted a study on "HIV Risk Reduction among Detained Sample" by using Randomized control trail, in Denver, Colorado district. 484detaind sample received 1 of 3 group-based interventions and the result was condom-use behaviour measured as frequency of condom use during sex (ranging from never to always) decreased o ver time, although the Group psychologic intervention and Group psychologic intervention along with Group motivated enhancement therapy interventions mitigated this tendency at the 3, 6 and 9 month follow-up assessments. Although both active interventions were significantly more successful than the GINFO condition; and the pattern of effects favoured the Group psychologic intervention and Group psychologic intervention along with Group motivated enhancement therapy, there were no statistically significant differences between the Group psychologic intervention and Group psychologic intervention and Group motivated enhancement therapy interventions.

Morrison-Beedy .D (2009) conducted a study on "Preliminary efficacy of a comprehensive HIV prevention intervention for abstinent adolescent girls". 54 sexually abstinent girls were taken for the study. The intervention resulted in a large effect for information (d=1.11); small to large effects for the motivational measures (d=.34-.88), and a moderate effect for a measures of behavioural skills (d=.67). The results indicate that antecedents of sexual risk behaviour change were improved by a gender-specific theoretically guided intervention.

Campsmith M.L. Rhodes et al (2009) conducted a study on "Undiagnosed HIV Prevalence among Adults and Sample in the United States." The study revealed that an estimated 1,106,400 adults/sample that is 95% were living with HIV in the United States at the end of 2006; overall, 21.0% were undiagnosed. Whites had the lowest percentage undiagnosed (18.8%) compared with Hispanics/Latinos (21.6%), blacks/African Americans (22.2%), American Indians/Alaska natives (25.8%) and Asians/Pacific Islanders (29.5%). Men exposed through heterosexual contact had the highest (26.7%) followed by men who have sex with men (23.5%).

Rajasekaran. S. et al (2009) conducted a study on Demographic & clinical profile of HIV infected children accessing care at Chennai. The results were showed that 1,768 new pediatric patients access care from 2002 to 2004. Children aged less than 5 years were 49.9%. 1115 children had (63%) tuberculosis. Significantly, 14.9 and 20.6% children had extra-pulmonary TB and disseminated TB respectively. Lower (15.2%), oral/esophageal candidiasis (13.5%), wasting (6.1%) and diarrhoeal disorders (3.5%) were the common clinical manifestations.

Arora.u. (2008) conducted a study on "Time trends of pediatric HIV infection in North India". Time trends were ascertained over a 15-year period to assess the impact of information, education and communication programme launched by National AIDS Control Organization. Data indicates that the total number of HIV positive cases increased 10-fold over the last 10 years. During 1991, 41 cases were recorded; the number increased to 439in year 2001, and 574 in 2004 (r=0.98). A similar trend was observed in the pediatric age group. During the initial 5years i.e., 1987 to 1992 only 7 pediatric cases were documented positive while the number increased to 45 in the year 2001 to 64 in the year 2004 with a cumulative figure of 323 children.

Section B : Studies related to Knowledge and attitude of adolescents regarding HIV

Gao.X et al (2012) conducted a study regarding the Effectiveness of school-based education on HIV/AIDS knowledge, attitude, and behavior among secondary school students in Wuhan, China. The study was conducted in three middle schools and two high schools in Wuhan, China, which included 702 boys and 766 girls, with ages from 11 to 18 years old. . The intervention was a one-class education program about HIV/AIDS for participants. HIV/AIDS knowledge, attitude, and high-risk behaviors were investigated using an anonymous self-administered questionnaire before and after the education intervention. Approximately 10% to 40% of students had negative attitudes about HIV/AIDS before the intervention. After the intervention, all of the students had significant improvements in knowledge and attitude about HIV/AIDS , indicating that educational intervention increased the students' knowledge significantly and changed their attitudes positively. Analyses indicated that before the intervention the students' level of knowledge about HIV/AIDS was significantly associated with grade, economic status of the family, and attitudes toward participation in HIV/AIDS health information campaigns.

The study concluded that HIV/AIDS education programs were welcomed by secondary students and positively influenced HIV/AIDS-related knowledge and attitudes.

Yukai du.et al (2012) conducted a study to assess the effectiveness of school based education on HIV/AIDS knowledge ,attitude, and behaviour among secondary schoolstudents in Wuhan, china. The study revealed that misconceptions about basic knowledge and non transmission modes of HIV/AIDS among all the students prevail. Approximately 10% to 40% of students had negative attitudes about HIV/AIDS before the intervention. After the intervention, all of the students had significant improvements in knowledge and attitude about HIV/AIDS ($p< 0.05$) indicating that educational intervention increased the students knowledge significantly and changed their attitudes positively. As to the basic knowledge ,80% of the students knew before the invention that " AIDS is an infectious disease but can be prevented". This rate is increased to more than 90% after the education. Most students believed that being infected with HIV would never happen to them because HIV/AIDS is a social problem and not a school problem. Thus before the education , few students cared about people with HIV/AIDS and whether those who are infected really need their help. After the intervention , a large number of students changed their negative attitude to a positive one.

Lal p etal (2012) conducted a study regarding the awareness about HIV/AIDS among senior secondary school children of Delhi in the present study, majority of the students 74.9% belonged to the age group of 15- 17 years. Most of them (60%) were females. Only 51.4% were able to write the full form of aids and only 19.9% were able to write the full form of HIV, in the present study, majority of the students (74.9%) belonged to the age group of 15-17 years. The mean age was 15.8 ± 0.8 years . Most of them (60%) were females. All the students had heard of HIV/AIDS although only 51.4% were able to write the full form of AIDS and only 19.9% were able to write the full form of HIV, gaps were seen in the awareness about other modes of transmission wherein only 31.1% and 23.4% cited blood transfusion and mother to baby transmission as routes of transmission, respectively. Only 72% of students were aware about HIV/AIDS as being preventable. Moreover, awareness about the different methods of prevention was rather low. Only 14.9% had knowledge about condoms as a means of protection, which awareness was significantly higher amongst boys. With regard to the sources of information about HIV/AIDS, 79.6% of the students mentioned that television and radio were the main sources of information to them. A majority (77.8%) of students had a favorable attitude

towards people living with HIV/AIDS (PLWHA), stating that such patients should be allowed to pursue/continue studies or allowed to work in common work places. About 51.6% of students in the present study felt that PLWHA'S must be hospitalized while 33.3% were in favour of home care. There is a strong need that school education must directly address stigmatizing attitudes about HIV/AIDS, gaps in HIV/AIDS knowledge and awareness of HIV-related health resources.

David.G.white.et al(2011) conducted a study on the knowledge level about HIV/AIDS among American sample aged 16 to 19. It has been assessed on several occasions, showing that in recent years their knowledge base has improved. The knowledge bases of British sample and of sample younger than 16 have been largely ignored. In attempting to assess the likely impact on present or future behaviours of increasing sample' knowledge base about AIDS it is important to also know something of sample' attitudes to intimate relationships and to sex within those relationships. Previous studies have not linked these two aspects. In this study two hundred London schoolchildren aged 14 and 15 years completed a questionnaire tapping both their knowledge about HIV infection and its transmission and their attitudes to intimate relationships. Their answers revealed that they had absorbed the simple media messages about AIDS, that it kills and that use of a condom during sex offers protection. However they were less well informed on detailed aspects of prevention, although, worryingly, they believed that they knew all that they needed to about preventive measures. The majority had attitudes to intimate relationships that were compatible with the message of restricting their number of sexual partners; however, a significant minority did not. The latter were more likely to deny the risk associated with promiscuity. It is suggested that school-based AIDS education programs should help individuals to develop new attitudes to intimate relationships that are compatible with risk avoidance.

Kumar et al (2010) conducted a study to assess their knowledge on HIV/AIDS among engineering students in lucknow. In that study response rate of 87% was obtained (174 out of 200). Overall, females showed less knowledge pertaining to issues related to human sexuality and HIV transmission, as compared to their male peers. Anal intercourse was observed as a risk for HIV transmission by 3% of females as compared to 20% of males. In general, there were considerable misconceptions regarding the spread and risk of HIV transmission among all engineering students. Attitudes of most of the students toward

HIV-infected individuals could be best described as ambivalent. Interesting to note that female students showed more positive attitude towards HIV infected people than their male peers. Findings suggest the need of integrating IEC activities and BCC activities promotion in the community starting from the initial stages mainly concentrating on teenagers and youngsters

Sudha A Raadi et al(2010) undertaken a study to evaluate the effectiveness of planned teaching programme on knowledge of sex education among adolescent girls in karnataka. 65 adolescent girls were selected for this study. The study revealed that in the pretest majority of the girls 40(61.53%) had average knowledge, 14(21.53%) had good knowledge,11(16.52%) had poor knowledge. Where as in the post test 3(4.61%)had average knowledge, 62(95.38 %) had good knowledge. There was a evident increase in the knowledge scores in all the areas included in the study after the administration of planned teaching programme. It was proved that planned teaching programme was effective in creating the awareness on importance of sex education and sexually transmitted infections, prevention of STD and HIV/AIDS transmission, and focusing the reproductive health hazards

Jaiswal.et al (2008) conducted a study to assess the knowledge, attitude and practice of high school students regarding HIV/ AIDS. The study revealed that Knowledge on some aspect of the disease was quite low in the study group. 45.8% had prior knowledge of HIV, 65.2% knew that HIV/AIDS could be transmitted by sharing same needle, 46.2% knew that vaccine is not yet available for HIV/AIDS. Knowledge about STI was also quite low, 41.5% knew that pus in the urine is a symptom of STI and 41.7% knew that STI is curable. 4.2% of the study group had previous sexual intercourse, 64.2% had sexual intercourse with friend and 35.17% had sexual intercourse with commercial sex workers. 1.8% would commit suicide if they contracted HIV/AIDS. According to sex wise distribution of the sample, female's knowledge about HIV was low 43.2% as compared to male 48%, male's knowledge about transmission of HIV/AIDS from pregnant mother to child was low; 89.7% as compared to female's knowledge 94.2%. Female's knowledge about commercial sex worker as high risk group was low (87.8%) as compared to male's knowledge 90.6

Section C : Studies related to Knowledge and attitude of People living with HIV regarding HIV /Aids

Mhalu, A.etal(2013) conducted a cross-sectional study to describe common HIV risk behaviors among 282 youth living with HIV aged between 15-24 , in Tanzania. The prevalence of unprotected sex was 40 percent among males and 37.5 percent among females. Approximately 16 and 11 percent of females and males, respectively, reported engaging in multiple sexual partnerships. Knowledge about sexually transmitted infection . prevention and transmission was low overall, but knowledge about STI symptoms and complications was relatively high. The majority reported engaging in risk behaviors with partners of unknown HIV status, and younger respondents aged 15-19, were three times more likely than older youth to engage in unprotected sex. Respondents who were using antiretroviral herapy (ART) were significantly less likely to engage in risky sexual behaviors, including multiple sexual partners, compared to those not on ART. Those who did not drink alcohol were 60 percent less likely to report unprotected sex.

Leyna (2013) Conducted a cross sectional study to identify the risky behaviour among young people living with HIV attending care and treatment clinics in Tanzania. A total of 282 HIV;positive patients aged 15-24 were interviewed about their sexual behaviours using a questionnaire. The study revealed that Prevalence of unprotected sex was 40.0% among young males and 37.5% among young females . Multiple sexual partnerships were reported by 10.6% of males and 15.9% of females . More than 50% of the participants did not know about the HIV status of their sexual partners. A large proportion of participants had minimal knowledge of transmission in males that is 46.7% and in females that is 60.4% and regarding prevention of sexually transmitted infections, 65.3% males and 73.4% females had minimal knowledge.

Jones.V et al (2012) conducted a study to determine the effectiveness of an HIV/AIDS educational intervention on adolescents' knowledge and perceptions of susceptibility and severity of HIV/AIDS. A quasi-study design was used to conduct this study amongsecondary school students in Trinidad and Tobago. A total of 196 secondary school students (from nine schools) between the ages of 11 and 18 years participated in the study, 92 in the intervention group and 104 in the comparison group. The results revealed that those in the comparison group had higher knowledge scores at post test than the intervention group, controlling for pretest knowledge (p=.005) but those in the

intervention group were more likely to plan to delay sexual initiation (p=.006). While knowledge scores increased for both groups, intention to delay sexual intercourse was only seen among the intervention group and within the younger age groups.

Sudha etal (2005) conducted a study in India regarding the level of stigma and discrimination towards people living with HIV**.** According to the survey involving 800 individuals in the city of Hyderabad, only 18% of the participants were willing to care for an HIV positive family member. Furthermore, 41% of the survey respondents stated that HIV infected students should not be allowed to attend schools, and about the same percentage reported that they would not buy things from a retailer suspected of being infected with HIV. More than 80% of the participants stated that they believed it to be inappropriate for people to tell others about their HIV status. The extent of the negative attitudes towards people living with HIV in this large city was further demonstrated by the fact that 51% of the respondents wanted a public list of the people infected with HIV in order to avoid them. The results of the study also showed that illiterate participants were more likely to exhibit discriminatory attitudes.

CHAPTER-III

RESEARCH METHODOLOGY

In simple terms methodology can be defined as it is used to give a clear cut idea on what the investigator is carrying out his research. In order to plan in a right point of time and to advance the research work methodology makes the right platform to the investigator to mapping out the research work in relevance to make solid plans.

This chapter deals with research approach, research design, variables, description of setting, population and sample, sample size, sampling technique, criteria for sample selection, description of the tool, validity and reliability, data collection procedure, pilot study, plan for data analysis and protection of human rights.

Research approach

The study has utilized quantitative research approach

Research design

The study has utilized Quasi experimental Pretest post test control group design

GROUP	PRE TEST	INTERVENTION	POST TEST
Study	O1	X	O2
Control	O1	-	O2

O1 –Pre test in Study and control group

X – Intervention (Life skill education package)

O2 – Post test in Study and control group

Variables:

Independent variable :

Life skill education package

Dependent variable :

Knowledge and attitude on HIV among adolescents with HIV.

Setting

The study was conducted among adolescents affected with HIV in Catherine Booth Hospital, Kanyakumari district which is situated 20 kilometres away from St Xavier's Catholic College Of Nursing, Chunkankadai, Nagercoil. In this hospital the The Salvation Army Community Health and Development department is conducting a project regarding HIV/AIDS and they are taking care of 72 HIV Positive adolescents. Here the investigator selected adolescents for the study. The control group population as well as the study group population were selected from that group.

Population

Target population:

Adolescents with HIV

Accessible population:

The population included for this study were adolescents with HIV in Catherine Booth Hospital, Kanyakumari District

Sample

Sample for this study were adolescents aged between 13- 18 years , who were affected with HIV, certified by the medical practitioner and attending a project on HIV/AIDS in the Salvation Army community health and development programme in Catherine Booth Hospital , Nagercoil.

Sample size

The sample size consists of 60 adolescents with HIV. Among these 30 adolescents were purposively selected for study group and 30 for control group**.**

Sampling technique

Purposive sampling technique was adopted for the study.

Criteria for sample selection

Inclusion criteria

- Adolescents in the age group of 13 to 18 years
- Adolescents who were diagnosed to have HIV positive , certified by a medical practitioner.
- Adolescents who were coming to the hospital for regular follow up.

Exclusion criteria

- Adolescents with HIV , who are critically ill and certified by a medical practitioner.

Description of the tool

The tool used in this study has 2 parts (**ANNEXURE-X**)

Section: A

Demographic variables such as age, sex, economic status, educational status, religion, type of family, living area.

Section: B

Structured questionnaire to collect data regarding knowledge and attitude scale to collect data regarding attitude

Scoring key for knowledge questionnaire:

- 71 and above – adequate knowledge
- 35 - 70 -- moderate knowledge
- Below 35 -- low knowledge

Scoring key for attitude questionnaire:

- Strongly disagree- 1
- Disagree -2
- Uncertain – 3
- Agree –4
- Strongly agree -5

Below 50% - Negative attitude

Between 50% to 71% - Neutral attitude.

Above 71% - positive Attitude

Description of Intervention

Life skill education package is an educational package given by USAID which was devised by the investigator and validated by the experts. This package consists of four sections. The first section contains activities regarding HIV, the entry of HIV in to the human body and regarding the immune power. Explanations were given in between the activity by making the adolescents to stand like a statue. The second section consists of activities regarding the portal of entry of HIV into the body .This was explained through chart. The third exercise is regarding the behaviour's which can be or can't be practiced by the individual. This was also explained through chart .The colour coding was given in the chart. Red colour indicates that the particular behaviour is harmful , green colour indicates that the particular behaviour is harmless , and yellow colour indicates that the activity is harmless unless there is any open wound. Clinical manifestations were explained through power point presentation. A role play was conducted to change the negative

attitudes of the adolescents. Each activity was given for 30 minutes . Pamphlets were given at the end of the session

Content validity

The content validity of the tool was ascertained by the expert opinion from 2 medical practitioners and 3 nursing experts. The experts gave their opinions and suggestions for further modification of items to improve the clarity and content of the question. The formal tool was prepared as per the suggestion and advice given by experts. (**ANNEXURE –III, IV,V)**

Reliability of the tool

The reliability of the tool was obtained by test retest method. The calculated value for knowledge questionnaire was r=0.9 and for attitude r= 0.9 ,which signifies that the tool is highly reliable

Pilot study

Pilot study was conducted in, kattuvilai sub centre, which belongs to The Salvation Army Community Health and Development programme ,Catherine booth hospital, Nagercoil .The pilot study was conducted among 6 adolescents . 3 study group and 3 control group were selected . Pre test was done to test the knowledge and attitude for both study and control group. Then life skill education package was given to study group. In the life skill education package there are four sections. The first section contains activities regarding HIV, the entry of HIV in to the human body and regarding the immune power. The second section consists of activities regarding the portal of entry of HIV into the body .This was explained through chart. The third exercise is regarding the activities which can or can't be done by the individual. This was also explained through chart. While explaining itself the sample were asked to perform the activities. Clinical manifestations were explained through power point presentation. A role play was conducted to change the negative attitudes of the sample. Pamphlets were given at the end of the session. Post test was done to both study and control group , after seven days. Analysis of the data was done by using descriptive and inferential statistics. The tool was reliable and scoring was found feasible and practicable. No changes were made and investigator proceeded for main study.

Procedure for data collection

After obtaining formal approval from the principal, the investigator proceeded with data collection. The investigator selected adolescents according to the inclusive criteria. Adolescents were selected using purposive sampling technique, 30 for study and 30 for control group. On the first week of Saturday and in the second week of Saturday, the adolescents were selected for study group. On the third and the fourth week of Saturday the adolescents were selected for control group. For assessing knowledge, structured questionnaire was given, which includes 15 items. Rating scale was given to assess the level of attitude . Questionnaire regarding knowledge and rating scale for attitude was given to both study group and control group. Life skill education package was given only to the study group . And after one week post was done for the study group and control group participants. Six adolescents from the control group didn't participate in the post test. So the investigator done the post test individually in their homes. The investigator established rapport with the adolescents and assured that the information would be kept confidential.

Plan For Analysis

Data collected was analyzed using both descriptive and inferential statistics such as mean, standard deviation, chi square, and paired and unpaired 't' test.

Descriptive statistics

- Frequency ,percentage, Mean and standard deviation were used for categorical data

Inferential statistics

- Paired 't' test was used to compare pre test and post test level of knowledge and attitude among adolescents with HIV in study group and control group.
- Unpaired 't' test was used to compare post test level of knowledge and attitude on study group and control group.
- Chi-square was used to find out the association of post test level of knowledge in adolescents with HIV between the study group and control group with their selected demographic variables.**(ANNEXURE –XII)**

Protection of human rights

This study was conducted after the approval of the dissertation committee of St. Xavier's Catholic College of Nursing. Permission was obtained from the Director of community department in Catherine Booth Hospital, Nagercoil **(ANNEXURE-II).** Consent was obtained from each subject before starting the data collection. Assurance was given to the study subjects regarding the confidentiality of the data collected **(ANNEXURE-VI).**

CHAPTER – IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the analysis and interpretation of the data collected among HIV affected adolescents to evaluate the effect of life skill package on HIV . The data collected from the adolescents were tabulated, analyzed and presented in the tables and figures and interpreted under the following sections based on the objectives and hypotheses of the study. This chapter is divided into three sections.

Section-A:

I. Distribution of adolescents according to the selected demographic variables in Study group and Control group.

Section-B:

I. Distribution of adolescents in study group and control group according to the post test level of knowledge
II. Distribution of adolescents in study group and control group according to the post test level of attitude

Section-C:

Testing Hypotheses

I. Comparison of pre test and post test scores of knowledge and attitude on HIV among HIV affected adolescents in study and control group
II. Association between the post test level of knowledge and attitude in Study group and control group with selected demographic variable

SECTION-A

I- DISTRIBUTION OF ADOLESCENTS ACCORDING TO THE SELECTED DEMOGRAPHIC VARIABLES IN STUDY GROUP AND CONTROL GROUP

Table 4.1: Frequency and percentage distribution of adolescents according to the selected demographic variables

N= 60

S.No	Demographic variables	Study group (n=30)		Control group (n=30)	
		f	%	f	%
1	**Age**				
	a) 13 – 15 years	13	43.33	12	40
	b) 16-18 years	17	56.67	18	60
2	**Sex**				
	a) Male	11	36.67	19	63.33
	b) Female	19	63.33	11	36.67
3	**Economic status**				
	a) Below Rs.5000	27	90	13	43.3
	b) Rs. 5001 - 10000	3	10	15	50
	c) Above 10001	0	0	2	6.67
4	**Educational status**				
	a) 8^{th} std - 10^{th} std	14	46.67	13	43.33
	b) 10^{th} std – 12^{th} std	3	43.33	17	56.67
	c) School drop outs	3	10	0	0
5	**Religion**				
	a) Hindu	13	43.33	11	36.67
	b) Christian	7	56.67	12	40

	c) Muslim	0	0	6	20
	d) Others	0	0	1	3.33
6	**Type of Family**				
	a)Nuclear family	28	93.33	23	76.67
	b) Joint family	0	0	6	20
	c)Broken family	2	6.67	1	3.33
7	**Living area**				
	a)Urban	1	3.33	1	6.67
	b)Rural	28	93.34	25	80
	c)Semi urban	1	3.33	4	13.33

Table 4.1 shows that, distribution of adolescents according to the age depicts that in Study group , 13 (43.33 %) of them belonged to 13 -15 years of age, 17 (56.67 %) of them belonged to 16 -18 years of age. In Control group, 12 (40%) of them belonged to13 -15 years of age, 18 (60 %) of them belonged to 16 – 18 years of age.

Distribution of adolescents according to the Sex of the baby shows that in Study group ,11 (36.67 %) of them were male children ,19 (63.33%) of them were female children. In control group II, 19 (63.33%) of them were male children, 11 (36.67) of them were female children.

Distribution of adolescents according to the economic status in Study group , 27 (90%) of them from below RS.5000 , 3 (10%) of them from Rs. 5001 –Rs. 10000, 0(0%) of them from above Rs.10001. In control group, 13 (43.3%) of them from below RS.5000 , 15 (50%) of them from Rs. 5001 –Rs. 10000,,2 (6.67%) of them from above Rs.10001.

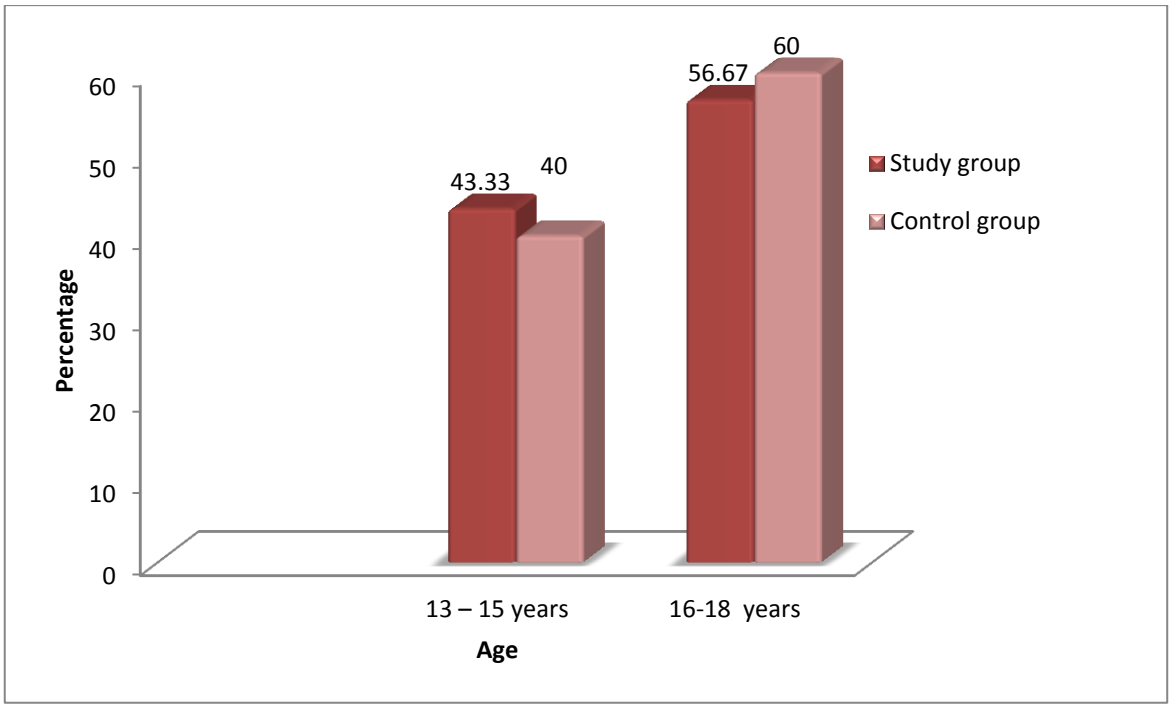
Distribution of adolescents according to the educational status shows that in Study group , 14(46.67%) of them are from 8th - 10th std , 3(43.3%) of them are from 10 th std - 12th std, and 3(10) of them are from school dropouts . In control group , 13 (43.33%) of

them are from 8th std - 10th std, 17(43.3%) of them 10th std -12th std and 0(0%) are from school dropouts.

Distribution of adolescents according to Religion shows that in Study group , 13 (43.33%) of them belongs to Hindu background, 7 (56.67%) of them belongs to christian background and 0 (0%) of them belongs to muslim background 0 (0%) of them are from other religion. In control group , 11 (36.67%) of them are from Hindu religion , 12 (40%) of them are from christian background and 6 (20%) of them are from muslim background and 1 (3.33%) of them are from other religion.

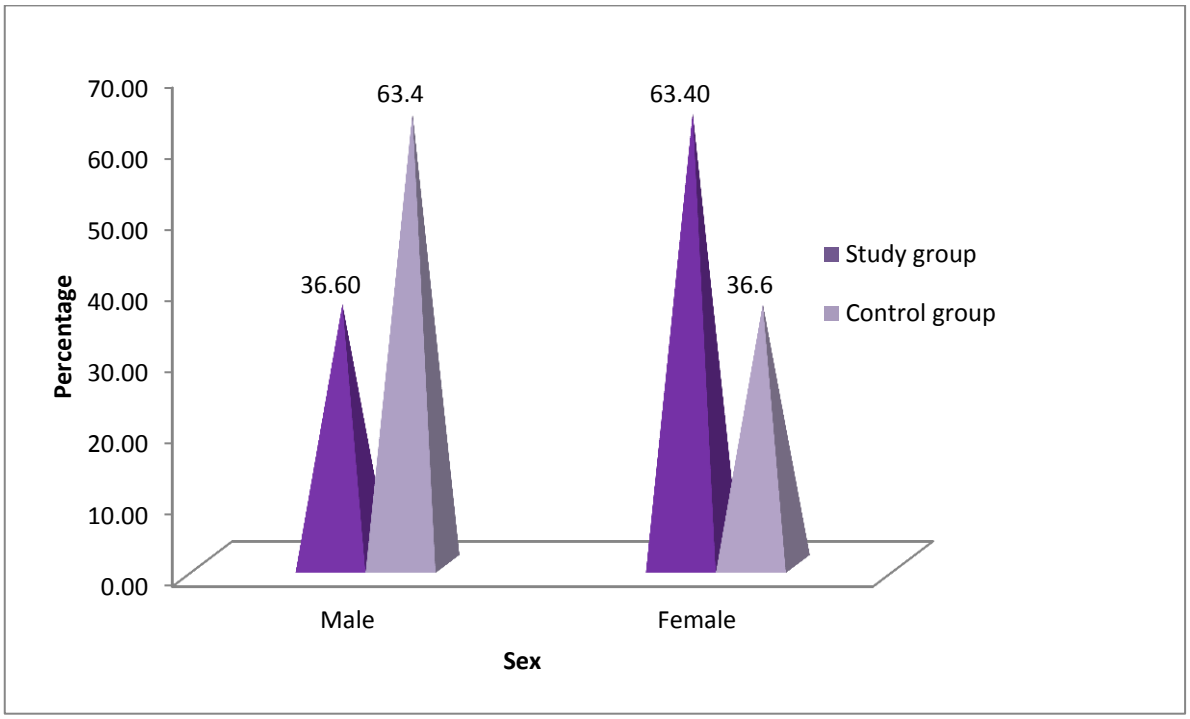
Distribution of adolescents according to type of family, in study group, 28(93.33%) of them belongs to Nuclear family, none of them (0%) belongs to joint family, 2(6.67%) of them belongs to broken family. In control group 23(76.67%) of them belongs to nuclear family, 6(20%) of them belongs to joint family, 1(3.33%) of them belongs to broken family.

Distribution of adolescents according to the living area, in study group, 1(3.33%) belongs to urban area, 28(93.34%) of them belongs to rural area, 1(3.33%) belongs to semi urban area. In control group, 1(6.67%) of them belongs to urban area, 25(80%) 0f them belongs to rural area, 4(13.33%) of them belongs to semi urban area.



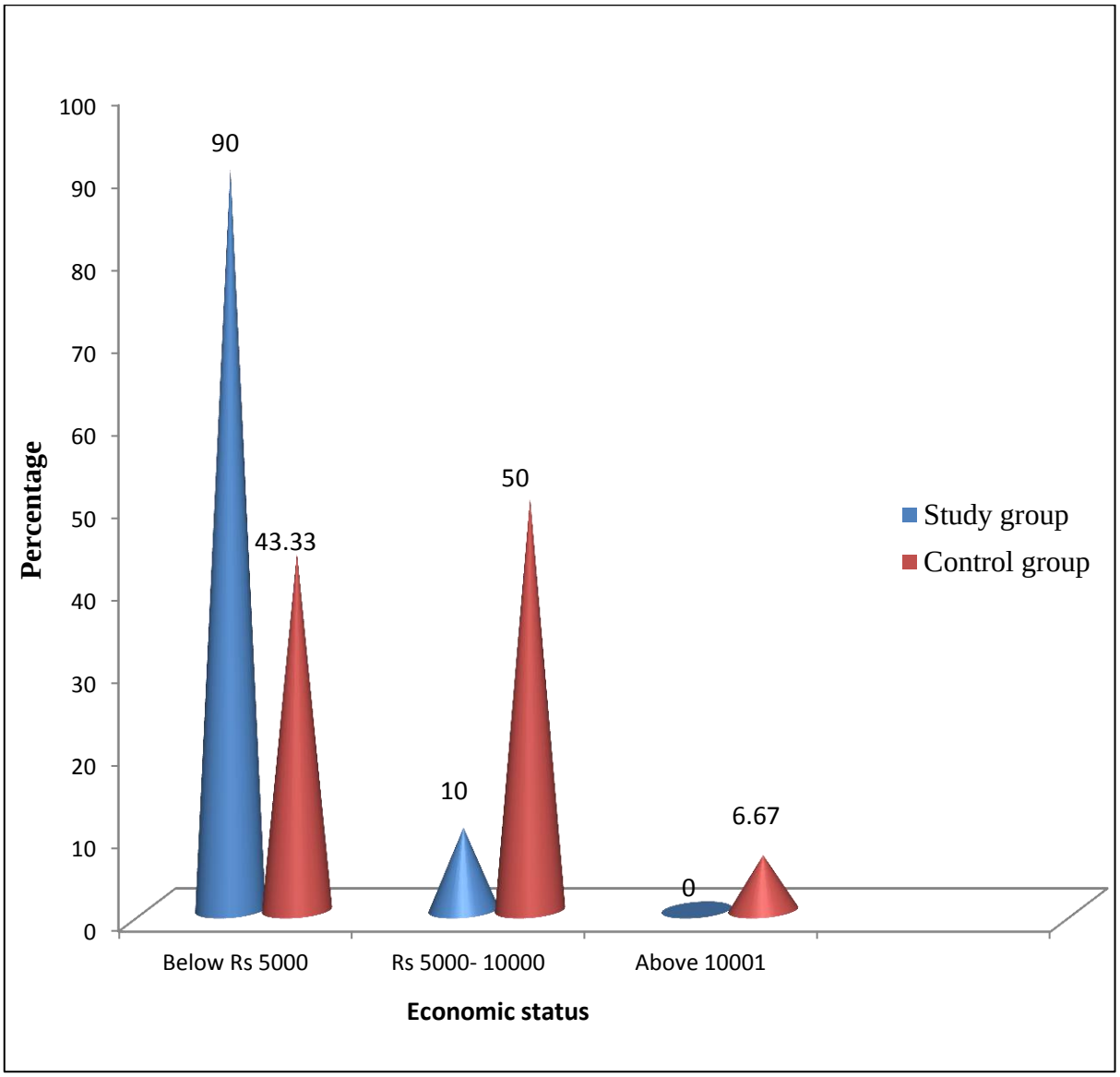
Distribution of adolescents according to age

Figure 4.1



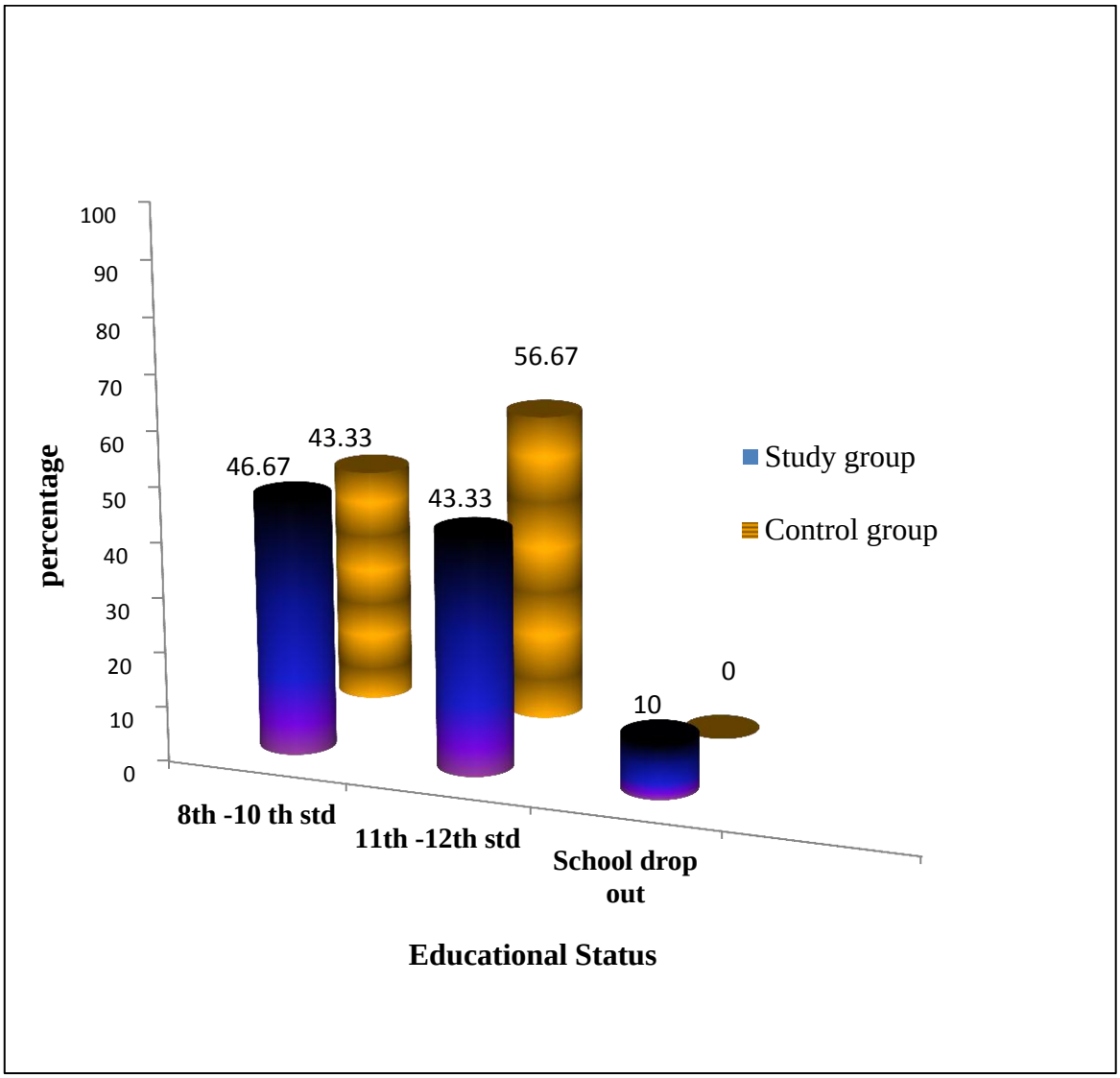
Distribution of adolescents according to sex

Figure 4.2



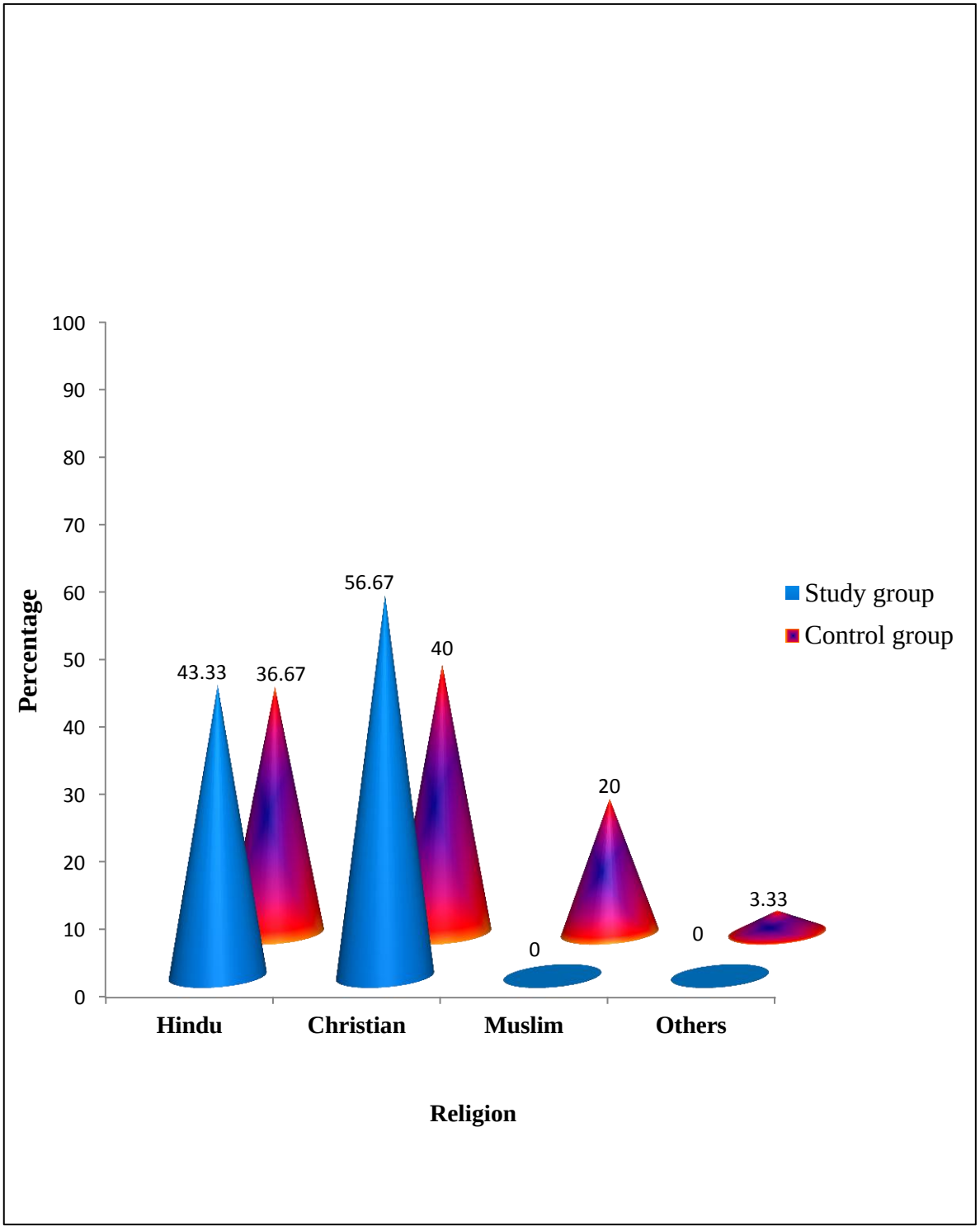
Distribution of adolescents according to the economic status

Figure 4.3



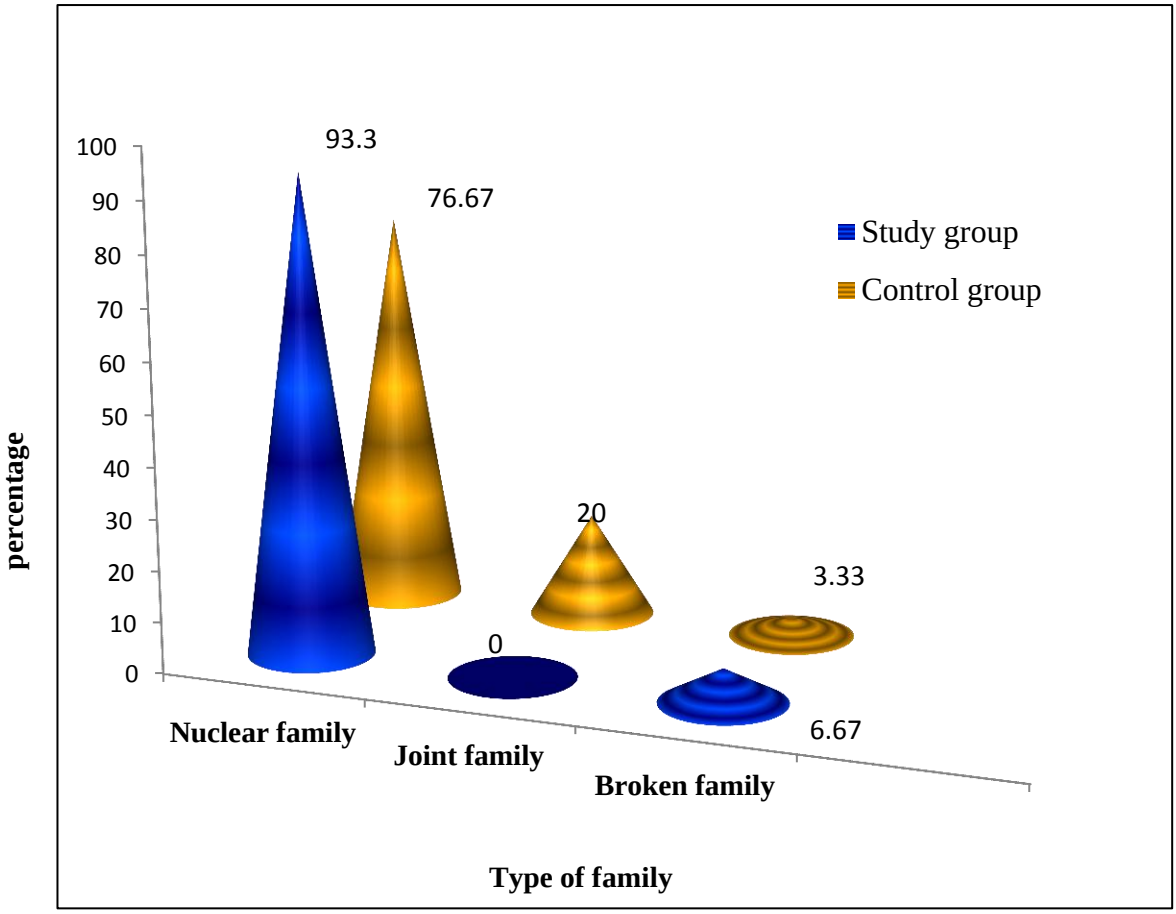
Distribution of adolescents according to the educational status

Figure 4.4



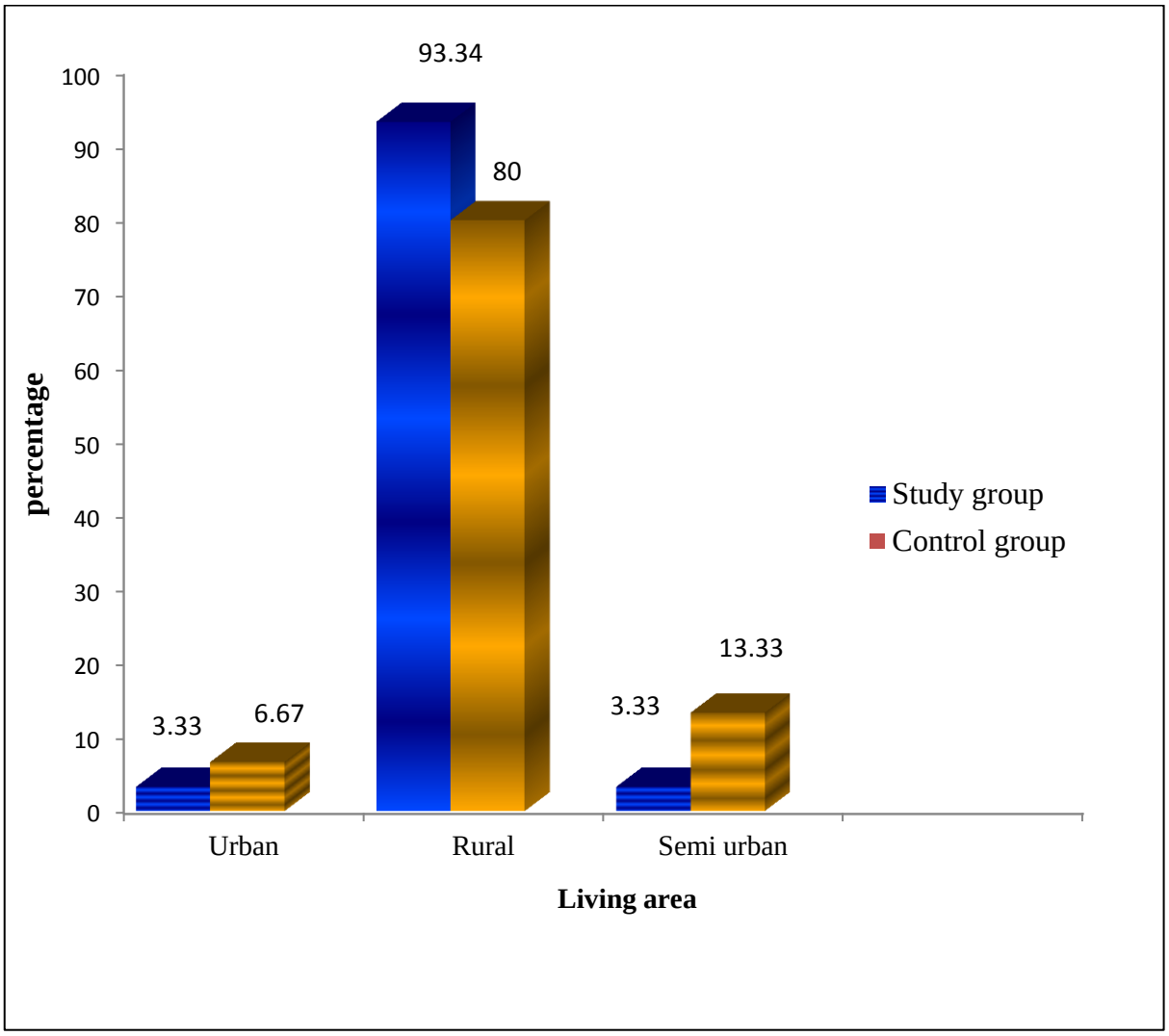
Distribution of adolescents according to Religion

Figure 4.5



Distribution of adolescents according to the type of family

Figure 4.6



Distribution of adolescents according to the living area

Figure 4.7

SECTION : B

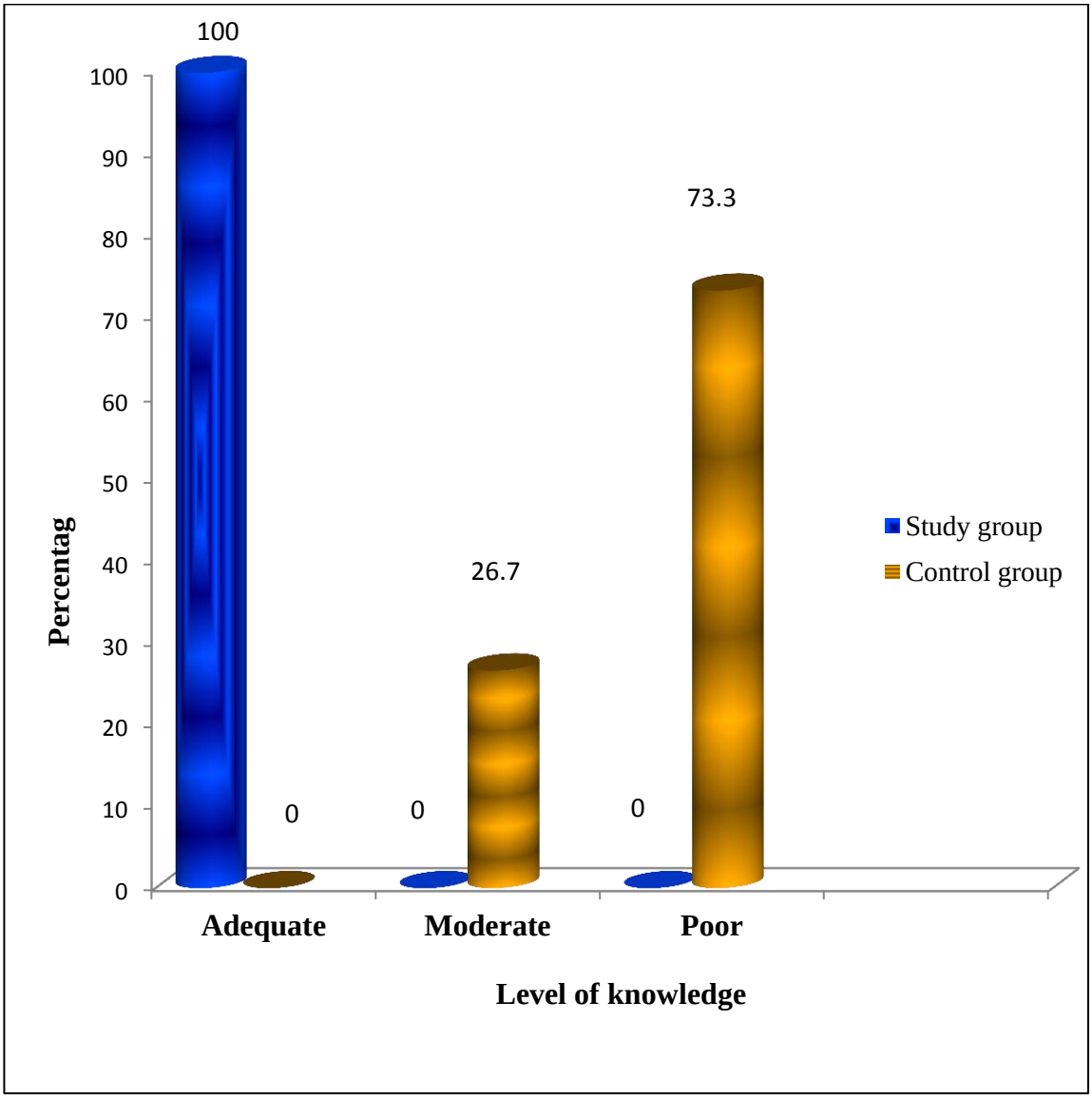
DISTRIBUTION OF ADOLESCENTS IN STUDY GROUP AND CONTROL GROUP ACCORDING TO THE POST TEST LEVEL OF KNOWLEDGE AND ATTITUDE.

Table 4.2: Frequency and percentage distribution of adolescents according to the post test level of knowledge in study group and control group

N=60

S.NO	Knowledge rating	Study group n=30		Control group n=30	
		f	%	f	%
1.	Adequate	30	100	0	0
2.	Moderate	0	0	8	26.7
3.	Poor	0	0	22	73.3

Table 4.2 shows that Knowledge level in Study group ,30 (100%) had adequate knowledge, 0 (0%) had moderate level of knowledge , 0 (0%) had poor knowledge. In Control group , 8 (26.7%) had moderate level of knowledge,22 (73.3%) had poor knowledge, 5(16.7) and none of them had adequate knowledge.



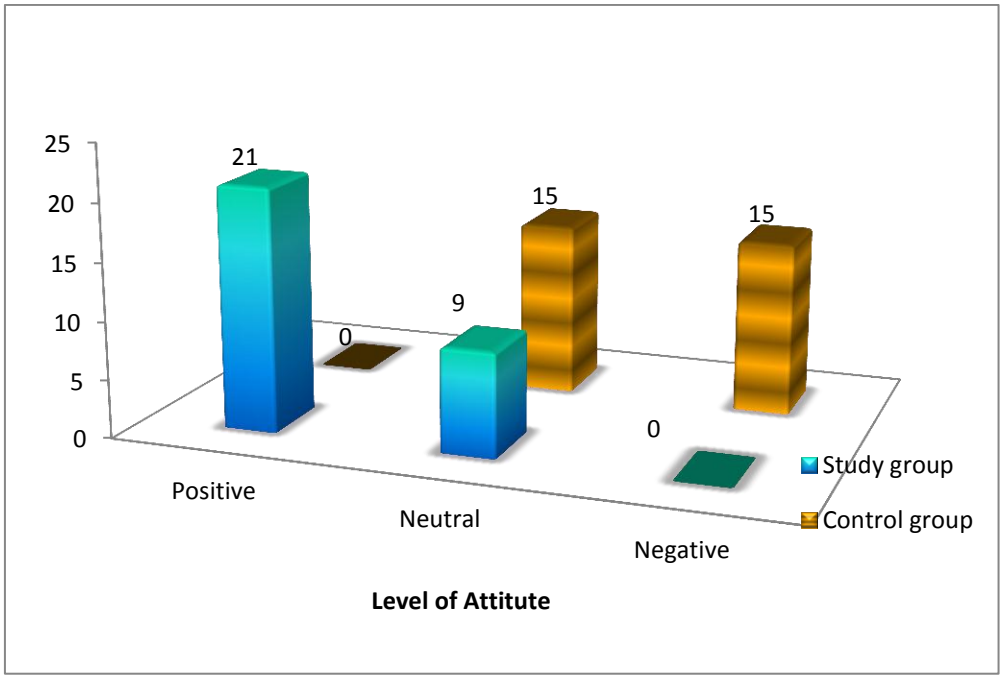
Distribution of adolescents according to the post level of knowledge in study group and control group

Figure 4.8

Table 4.3 Frequency and percentage distribution of adolescents according to the post test level of attitude in study group and control group

S.NO	Attitude rating	Study group n=30		Control group n=30	
		f	%	f	%
1.	Positive	21	70	0	0
2.	Neutral	9	30	15	50
3.	Negative	0	0	15	50

Table 4.3 shows that attitude level in Study group ,21 (70%) had positive attitude, 9 (30%) had neutral attitude , 0 (0%) had negative attitude. In Control group , 15 (50%) had neutral attitude ,15 (50%) had negative attitude, 0(0%) and none of them had positive attitude.



Distribution of adolescents according to the post test level of attitude in study and control group

Figure.4.9

SECTION :C

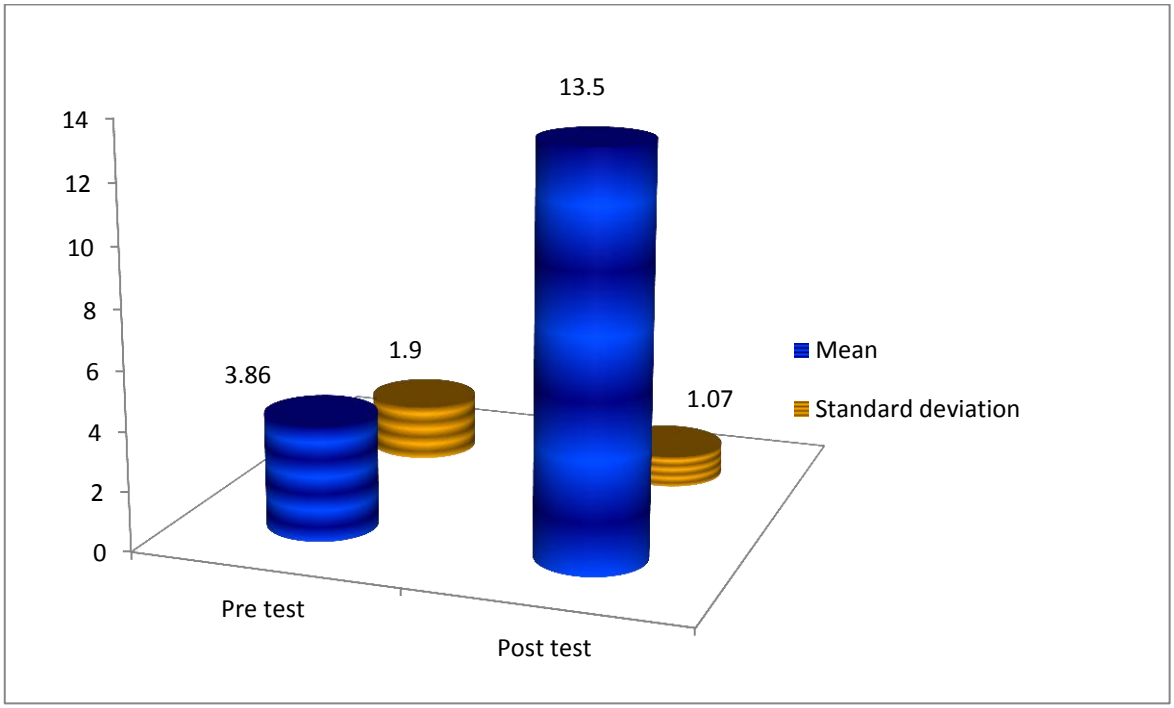
I. COMPARISON OF PRE TEST AND POST TEST SCORES OF KNOWLEDGE AND ATTITUDE ON HIV AMONG HIV AFFECTED ADOLESCENTS IN STUDY AND CONTROL GROUP

Table 4.4 Mean standard deviation of pre test and post test scores and 't' value of knowledge and attitude on HIV among adolescents with HIV in study and control group

N=60

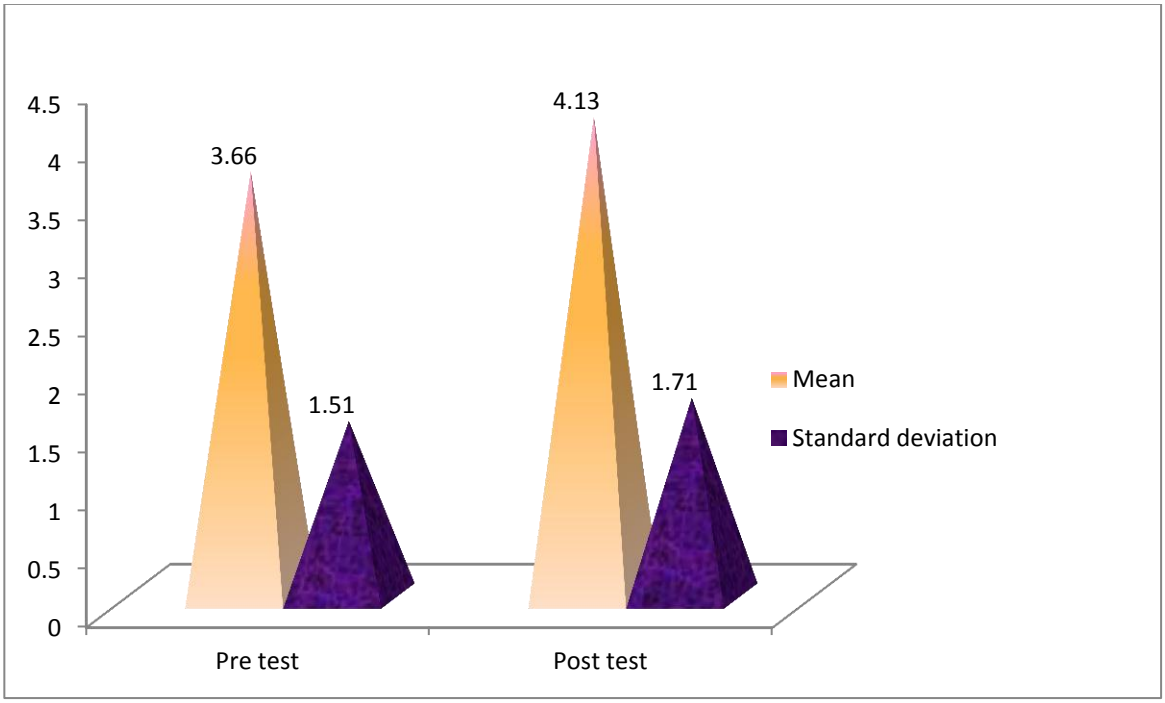
	Knowledge				' t' value	Attitude				' t' value
	Pre test		Post test			Pre test		Post test		
	Mean	Standard deviation	Mean	Standard deviation		Mean	standard deviation	Mean	standard deviation	
Study group	3.86	1.90	13.5	1.07	29.3	44.8	9.2	73.5	1.4	19.16
Control group	3.66	1.51	4.13	1.71	1.63	41.03	6.3	36.16	9.5	1.65

Table 4.4 shows that in study group for knowledge during the pre test the mean value was 3.86 and standard deviation was 1.90 and in post test the mean value was 13.5 and standard deviation was 1.07. In control group during the pre test the mean value was 3.66 and standard deviation was 1.51. And in post test the mean value was 4.13, and standard deviation was 1.71. The 't ' value was 29.3 for study group and 1.63 for control group. In attitude during the pre test for study group the mean value was 44.8, and standard deviation was 9.2. During the post test the mean value was 73.5 and standard deviation was 1.4. 'T' Value was 19.16. In control group during the pre test the mean value was 41.03 , the standard deviation was 6.3 . During the post test the mean value was 36.6, standard deviation was 9.5 and 'T' value was 1.65.



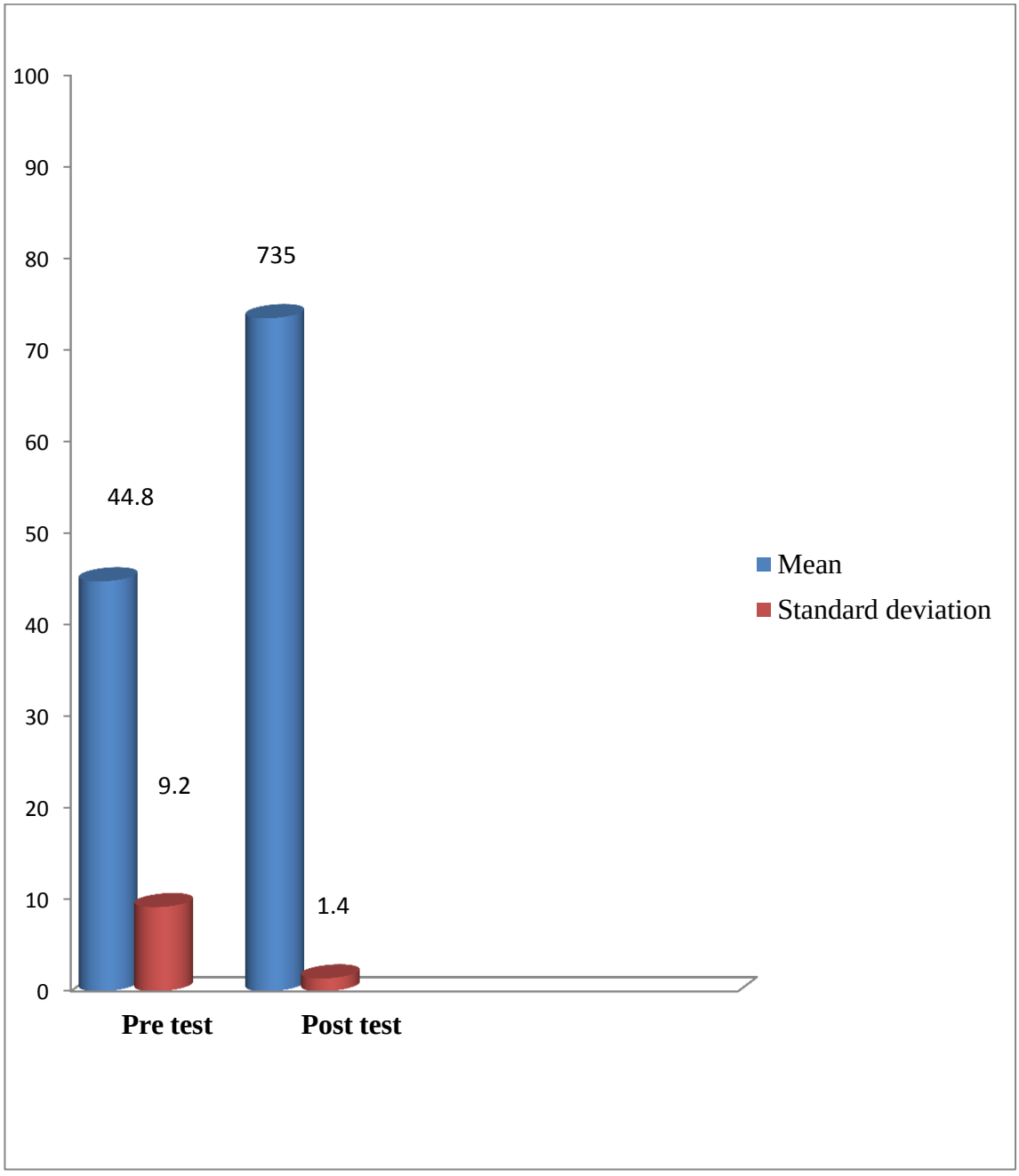
Distribution of adolescents according to the mean and standard deviation scores of pretest and post test level of knowledge in study group

Figure.4.10



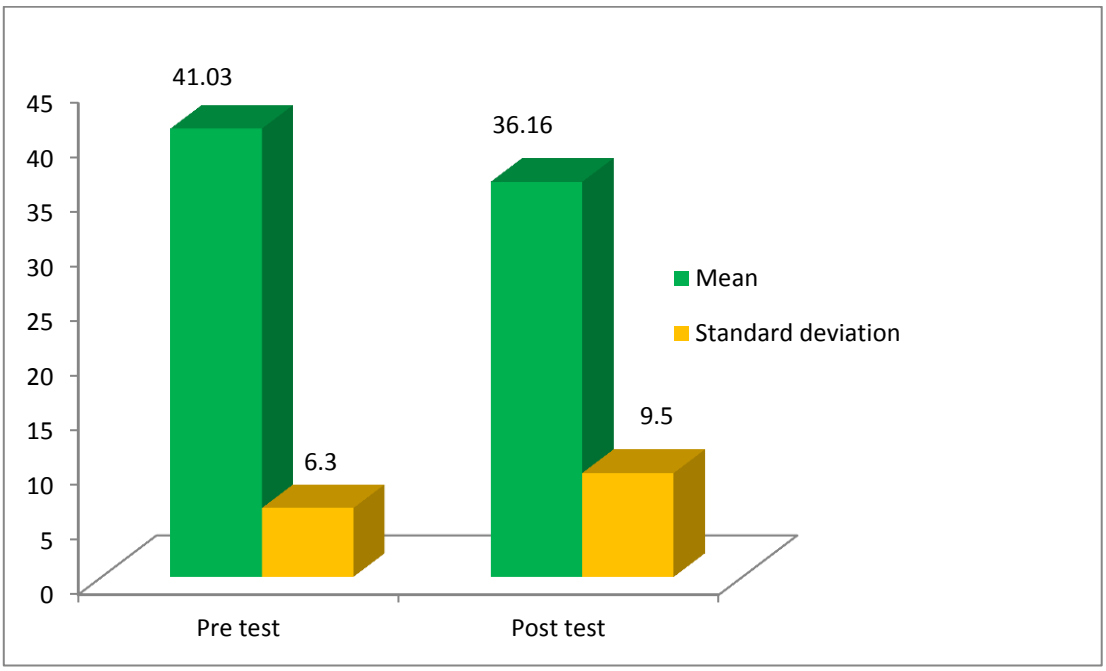
Distribution of adolescents according to the mean and standard deviation scores of pre test and post test level of knowledge in control group

Figure: 4.11



Distribution of adolescents according to the mean and standard deviation scores of pre test and post test level of attitude in study group

Figure: 4.12



Distribution of adolescents according to the mean and standard deviation scores of pre test and post test level of attitude in control group

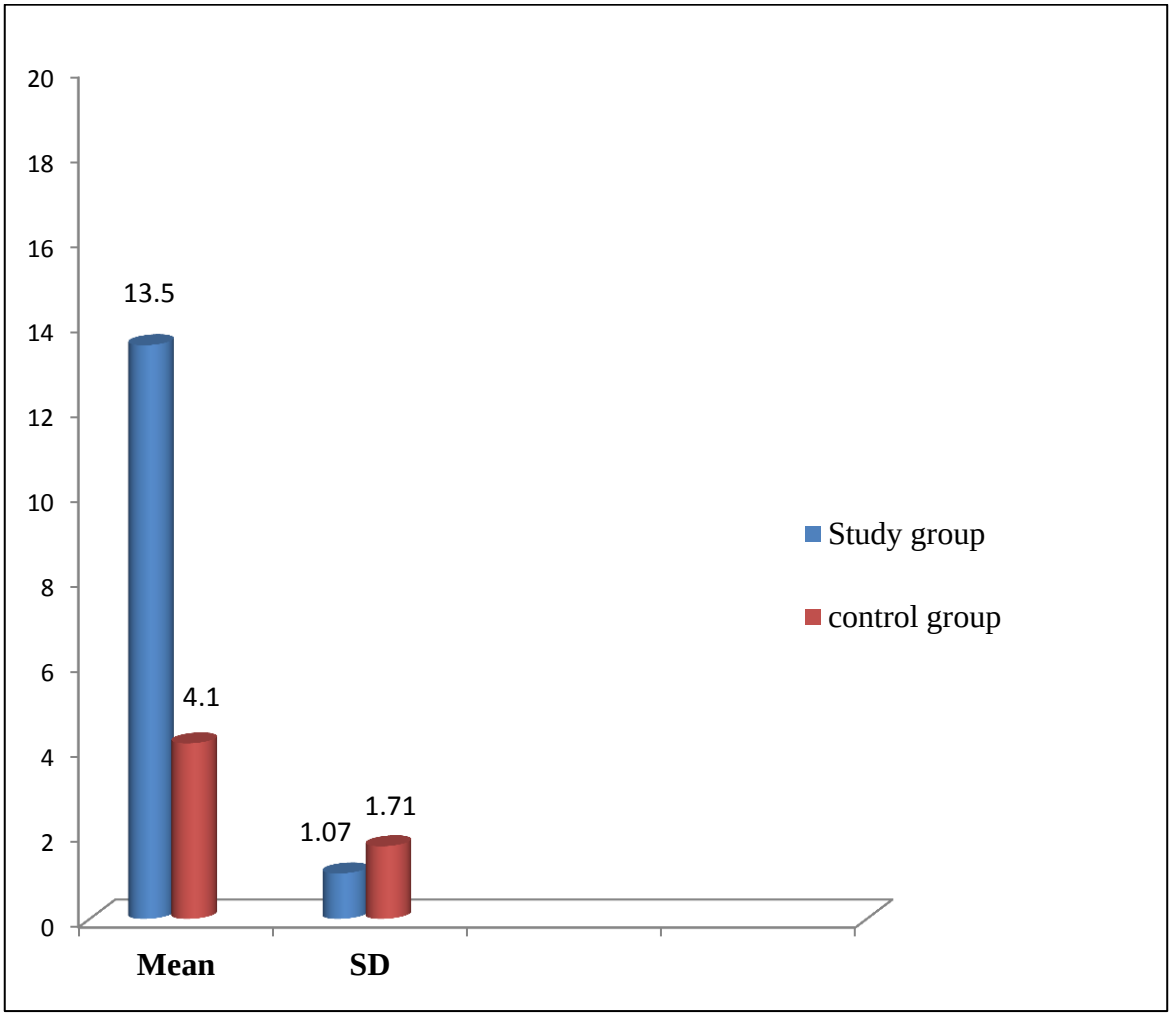
Figure: 4. 13

II. COMPARISON OF POST TEST SCORES OF KNOWLEDGE AND ATTITUDE OF HIV AMONG HIV AFFECTED ADOLESCENTS IN STUDY AND CONTROL GROUP

Table :4.5 Mean standard deviation and 't' value of post test scores in study and control group

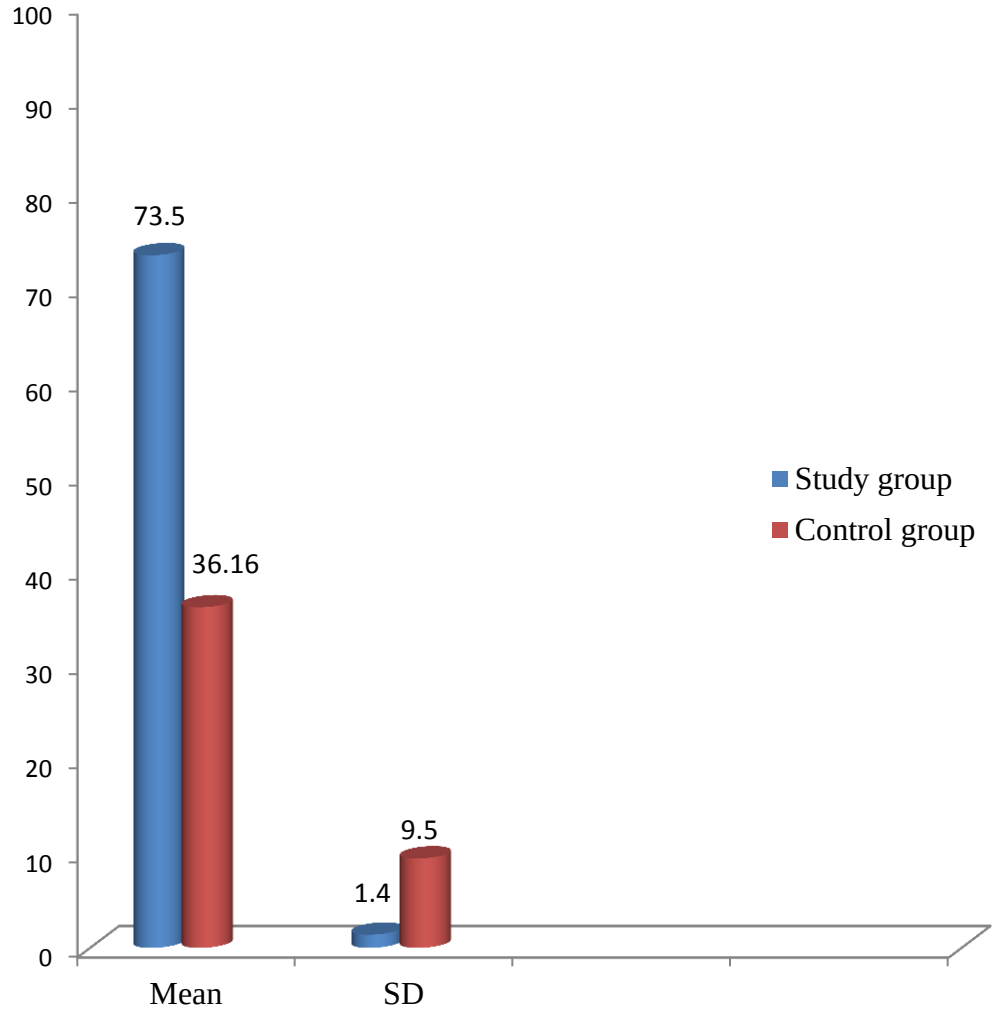
Variable	Study group		Control group		't' value
	MEAN	SD	MEAN	SD	
knowledge	13.5	1.07	4.13	1.71	27.56
Attitude	73.5	1.4	36.16	9.5	26

Table 4.5 shows that for knowledge in study group the mean value is 13.5 , the standard deviation was 1.07 and in control group the mean value is 4.13, the standard deviation is 1.71, and the 'T' value is 27.56. For attitude ,in study group the mean value is 73.5, the standard deviation is 1.4. and in control group the mean value is 36.6, the standard deviation is 9.5. And the 'T' value is 26**.**



Comparison between the post test level of knowledge in study and control group

Figure: 4.14



Comparison between the post test level of attitude in study and control group

Figure: 4.15

II-ASSOCIATION BETWEEN THE POST TEST LEVEL OF KNOWLEDGE IN STUDY GROUP AND CONTROL GROUP WITH SELECTED DEMOGRAPHIC VARIABLES.

Table 4.6: Association between the level of knowledge in Study group and Control group with selected demographic variables.

N=60

S.No	Demographic variables	Study group n=30			Control group n=30		
		df	Chi-square	Table value	df	Chi-square	Table value
1	Age	2	4.45	5.99	2	0.029	5.99
2	Sex	2	0	5.99	2	0.84	5.99
3	Economic status	4	0	9.49	4	2.71	9.49
4	Educational status	4	0	9.49	4	0.13	9.49
5	Religion	6	0	12.53	6	0.63	12.53
6.	Type of Family	4	0	9.49	4	0.11	9.49
7	Living area	4	0	9.49	4	4.82	9.49

Table 4.6 shows that in study group , on considering the age, the chi-square value was 4.45 , the table value at degrees of freedom 2 was 5.99. As per the sex the chi-square value was 0, the table value at degrees of freedom 2 was 5.99. In economic status, the chi- square was 0, the table value at degrees of freedom 4 was 9.49. As per the educational status ,the chi-square value was 0, the table value at degrees of freedom 4 was 9.49. In religion the chi-square value was 0, the table value at degrees of freedom 6 was 12.53. As per the type of family the chi-square value was 0, the table value at

degrees of freedom 4 was 9.49. According to the living area the chi- square value was 0, the table value at the degrees of freedom 4 was 9.49.

In control group, on considering the age the chi-square value was 0.029 , the table value at degrees of freedom 2 was 5.99. As per the sex the chi- square value was 0.84, the table value at degrees of freedom 2 was 5.99. In economic status, the chi- square was 2.71, the table value at degrees of freedom 4 was 9.49. As per the educational status ,the chi-square value was 0.13, the table value at degrees of freedom 4 was 9.49. In religion the chi-square value was 0.63, the table value at degrees of freedom 6 was 12.53. As per the type of family the chi-square value was 0.11, the table value at degrees of freedom 4 was 9.49. According to the living area the chi- square value was 4.82, the table value at the degrees of freedom 4 was 9.49.

Table4.7 Association between the level of attitude in study group and control group with selected demographic variables.

S.No	Demographic variables	Study group n=30			Control group n=30		
		df	Chi-square	Table value	df	Chi-square	Table value
1	Age	2	0.68	5.99	2	12.8	5.99
2	Sex	2	1.24	5.99	2	0	5.99
3	Economic status	4	0.01	9.49	4	2.66	9.49
4	Educational status	4	1.49	9.49	4	1.2	9.49
5	Religion	6	0.49	12.53	6	0.06	12.53
6.	Type of Family	4	0.38	9.49	4	2.04	9.49
7	Living area	4	0.79	9.49	4	1.04	9.49

Table 4.7 shows that in study group, on considering the age the chi-square value was 0.68 , the table value at degrees of freedom 2 was 5.99. As per the sex the chi-square value was 1.24, the table value at degrees of freedom 2 was 5.99. In economic status, the chi- square was 0.01, the table value at degrees of freedom 4 was 9.49. As per the educational status ,the chi-square value was 1.49, the table value at degrees of freedom 4 was 9.49. In religion the chi-square value was 0.49, the table value at degrees of freedom 6 was 12.53. As per the type of family the chi-square value was 0.38, the table value at degrees of freedom 4 was 9.49. According to the living area the chi- square value was 0.79, the table value at the degrees of freedom 4 was 9.49.

In control group, on considering the age the chi-square value was 12.8 , the table value at degrees of freedom 2 was 5.99. As per the sex the chi- square value was 0, the table value at degrees of freedom 2 was 5.99. In economic status, the chi- square was 2.66 , the table value at degrees of freedom 4 was 9.49. As per the educational status ,the chi-square value was 1.49, the table value at degrees of freedom 4 was 9.49. In religion the chi-square value was 0.06, the table value at degrees of freedom 6 was 12.53. As per the type of family the chi-square value was 2.04 , the table value at degrees of freedom 4 was 9.49. According to the living area the chi- square value was 1.04, the table value at the degrees of freedom 4 was 9.49.

CHAPTER –V

DISCUSSION

This study was done to evaluate the effectiveness of life skill educationpackage upon knowledge and attitude on hiv among adolescents in selected setting, kanyakumari district.

Distribution of adolescents according to their demographic variables.

In Study group , according to age, 13 (43.33 %) of them belonged to 13 -15 years of age, 17 (56.67 %) of them belonged to 16 -18 years of age. According to the Sex ,11 (36.67 %) of them were male children ,19 (63.33%) of them were female children. Regarding the economic status , 27 (90%) of them from below RS.5000 , 3 (10%) of them from Rs. 5001 –Rs. 10000, 0(0%) of them from above Rs.10001. According to the educational status shows that in Study group , 14(46.67%) of them are from 8th - 10th std , 3(43.3%) of them are from 10 th std - 12th std, and 3(10) of them are from school dropouts

According to Religion shows that in Study group,13 (43.33%) of them belongs to Hindu background, 7 (56.67%) of them belongs to christian background and 0 (0%) of them belongs to muslim background 0 (0%) of them are from other religion. Regarding the type of family, 28(93.33%) of them belongs to Nuclear family, none of them (0%) belongs to joint family, 2(6.67%) of them belongs to broken family . According to the living area, 1(3.33%) belongs to urban area, 28(93.34%) of them belongs to rural area, 1(3.33%) belongs to semi urban area.

In Control group, according t o age, 12 (40%) of them belonged to13 -15 years of age, 18 (60 %) of them belonged to 16 – 18 years of age. According to the sex , 19 (63.33%) of them were male children, 11 (36.67) of them were female children. Regarding the economic status, 13 (43.3%) of them from below RS.5000 , 15 (50%) of them from Rs. 5001 –Rs. 10000,,2 (6.67%) of them from above Rs.10001.

According to the educational status, 13 (43.33%) of them are from 8th std - 10th std, 17(43.3%) of them 10th std -12th std and 0(0%) are from school dropouts. Regarding the religion , 11 (36.67%) of them are from Hindu religion , 12 (40%) of them are from christian background and 6 (20%) of them are from muslim background and 1 (3.33%) of them are from other religion. . According to the type of family, 23(76.67%) of them belongs to nuclear family, 6(20%) of them belongs to joint family, 1(3.33%) of them belongs to broken family. According to the living area, 1(6.67%) of them belongs to urban area, 25(80%) 0f them belongs to rural area, 4(13.33%) of them belongs to semi urban area.

The first objective is to compare the pre test and post test level of knowledge and attitude on HIV among adolescents with HIV among study and control group.

In study group for knowledge during the pre test, the mean value was 3.86 and standard deviation was 1.90 and in post test the mean value was 13.5 and standard deviation was 1.07. The 't ' value was 29.3 for study group which is significant at $P<0.05$. It shows that life skill education package was effective in improving the knowledge and attitude of HIV among HIV affected adolescents.

In control group during the pre test the mean value was 3.66 and standard deviation was 1.51. And in post test the mean value was 4.13, and standard deviation was 1.71. The 't ' value was 1.63 for control group.

In attitude during the pre test for study group the mean value was 44.8, and standard deviation was 9.2. During the post test the mean value was 73.5 and standard deviation was 1.4. 'T' Value was 19.16. In control group during the pre test the mean value was 41.03 , the standard deviation was 6.3 . During the post test the mean value was 36.6, standard deviation was 9.5 and 'T' value was 1.65.

Jones.V et al (2012) conducted a study to determine the effectiveness of an HIV/AIDS educational intervention on adolescents' knowledge and perceptions of susceptibility and severity of HIV/AIDS. A quasi-study design was used to conduct this study among secondary school students in Trinidad and Tobago. A total of 196 secondary school students (from nine schools) between the ages of 11 and 18 years participated in the

study, 92 in the intervention group and 104 in the comparison group. The results revealed that those in the comparison group had higher knowledge scores at post test than the intervention group, controlling for pretest knowledge (p=.005) but those in the intervention group were more likely to plan to delay sexual initiation (p=.006). While knowledge scores increased for both groups, intention to delay sexual intercourse was only seen among the intervention group and within the younger age groups.

The investigator had utilized Imogene King's Goal Attainment Theory(1981) for the study. The first step of the theory consist of Judgement and Perception . According to that the investigator conducted the pre test for both study group and control group and assessed the level of knowledge and attitude of the adolescents on HIV and perceived the need of providing education to improve the knowledge and attitude.

The second objective is to evaluate the effectiveness of life skill education package on knowledge and attitude of adolescents with HIV in study group.

The mean value on knowledge among adolescents in study group was 3.86 during the pretest and13.5 in post test . The estimated 't' value was 29.3 which is significant at $p< 0.05$. It shows that life skill education package was effective in improving the knowledge. The mean value on attitude among adolescents in study group was 44.8 during the pretest and73.5 in post test .The estimated 't' value was 27.56 which is significant at $p< 0.05$. It shows that life skill education package was effective in improving the attitude. Hence the hypothesis(H1) is accepted.

While comparing the post test level of knowledge in Study and control group the mean value of knowledge in study group was 13.5 and in control group was 4.13. The estimated 't' value was 27.56 which is significant at $p< 0.05$. It shows that Life skill education package was effective in improving the knowledge among HIV affected adolescents. While comparing the post test level of attitude in Study and control group the mean value of attitude in study group was 73.5 and in control group was 36.16. The estimated 't' value was 26 which is significant at $p< 0.05$. It shows that life skill education package was effective in improving the attitude. Hence the hypothesis(H2) is accepted.

So results shows that life skill education package was effective in improving the knowledge and attitude of the HIV affected adolescents.

Sudha A Raadi et al(2010) undertaken a study to evaluate the effectiveness of planned teaching programme on knowledge of sex education among adolescent girls in karnataka. 65 adolescent girls were selected for this study.The study revealed that in the pretest majority of the girls 40 (61.53%) had average knowledge, 14(21.53%) had good knowledge,11(16.52%) had poor knowledge. Where as in the post test 3(4.61%)had average knowledge, 62(95.38 %) had good knowledge. There was a evident increase in the knowledge scores in all the areas included in the study after the administration of planned teaching programme. It was proved that planned teaching programme was effective in creating the awareness on importance of sex education and sexually transmitted infections, prevention of STD and HIV/AIDS transmission, and focusing the reproductive health hazards .

The next step of Imogene King's Goal Attainment theory includes action , reaction and interactio. Here the investigator prepared the adolescents for participating in the life skill education package. The life skill education package was provided to the adolescents in study group. In reaction the adolescents participated in the activities given through Life skill Education package .In interaction the investigator encouraged and monitored the level of knowledge and attitude.

The third objective is to find out the association between the post test level of knowledge and attitude in Study group and control group with selected demographic variables

There is no significant association between the level of knowledge and attitude of HIV among HIV affected adolescents with their selected demographic variables in Study group and Control group ($p<0.05$) level. Hence hypothesis H2 is not accepted.

CHAPTER –VI

SUMMARY, CONCLUSION, NURSING IMPLICATIONS, LIMITATIONS, AND RECOMMENDATIONS

This chapter deals with the summary of the study, conclusion, nursing implications, limitations and recommendations of the study.

SUMMARY

In Quantitative evaluative approach with Quasi experimental study pre test post test control group research design was used to determine the effectiveness of life skill education package on knowledge and attitude on HIV among adolescents with HIV. The conceptual framework was based on Imogene King's Goal Attainment Theory. The tool used in this study consisted of two parts. Part one was demographic variables, part two was the Structured questionnaire to assess the knowledge and attitude of HIV among adolescents affected with HIV.

Purposive sampling technique was used to select the adolescents and data was collected from the study participants in study and control group. The data were collected and analysed using descriptive and inferential statistics. The level of significance was assessed by $p < 0.05$ to test the hypotheses.

FINDINGS

The major findings of the study was summarized as follows:

- Regarding the knowledge, in Study group , during the pre test, 22 (73.3%) had adequate knowledge, 8 (26.67%) had moderate level of knowledge , 0 (0%) had adequate knowledge. In control group during the pre test 28 (93.3%) had poor knowledge, 2 (6.67%) had moderate level of knowledge, 0(0%) had poor knowledge.

- Regarding the attitude ,in control group , during the pre test 4 (13.33%) had positive attitude, 21 (70%) had neutral attitude, 5 (16.67%) had negative attitude. In Study group during the pre test 27 (90%) had neutral attitude, 3 (10%) had negative attitude , and none of them 0 (0%) had positive attitude.

- In Study group , during the post test ,30 (100%) had adequate knowledge, 0 (0%) had moderate level of knowledge , 0 (0%) had poor knowledge. In Control group , 8 (26.7%) had moderate level of knowledge,22 (73.3%) had poor knowledge, 5(16.7) and none of them had adequate knowledge.

- In Study group during the post test ,21 (70%) had positive attitude, 9 (30%) had neutral attitude , 0 (0%) had negative attitude. In Control group , 15 (50%) had neutral attitude ,15 (50%) had negative attitude, 0(0%) and none of them had positive attitude.

- In study group for knowledge during the pre test, the mean value was 3.86 and standard deviation was 1.90 and in post test the mean value was 13.5 and standard deviation was 1.07. The 't ' value was 29.3 for study group which is significant at $P<0.05$. It shows that life skill education package was effective in improving the knowledge and attitude of HIV among HIV affected adolescents.

- In control group during the pre test the mean value was 3.66 and standard deviation was 1.51. And in post test the mean value was 4.13, and standard deviation was 1.71. The 't ' value was 1.63 for control group.

- In attitude during the pre test for study group the mean value was 44.8, and standard deviation was 9.2. During the post test the mean value was 73.5 and standard deviation was 1.4. 'T' Value was 19.16. In control group during the pre test the mean value was 41.03 , the standard deviation was 6.3 . During the post test the mean value was 36.6, standard deviation was 9.5 and 'T' value was 1.65. Hence life skill education package was effective In study group for knowledge during the pre test, the mean value was 3.86 and standard deviation was 1.90 and in

post test the mean value was 13.5 and standard deviation was 1.07. The 't ' value was 29.3 for study group which is significant at P<0.05. It shows that life skill education package was effective in improving the attitude of HIV among HIV affected adolescents

- The mean value on knowledge among adolescents in study group was 3.86 during the pre test and13.5 in post test . The estimated 't' value was 29.3 which is significant at p< 0.05. It shows that life skill education package was effective in improving the knowledge. The mean value on attitude among adolescents in study group was 44.8 during the pretest and73.5 in post test .The estimated 't' value was 27.56 which is significant at p< 0.05. It shows that life skill education package was effective in improving the attitude.
- While comparing the post test level of knowledge in Study and control group the mean value of knowledge in study group was 13.5 and in control group was 4.13. The estimated 't' value was 27.56 which is significant at p< 0.05. It shows that Life skill education package was effective in improving the knowledge among HIV affected adolescents. While comparing the post test level of attitude in Study and control group the mean value of attitude in study group was 73.5 and in control group was 36.16. The estimated 't' value was 26 which is significant at p< 0.05.
- There is no significant association between the level of knowledge and attitude of HIV among HIV affected adolescents with their selected demographic variables in Study group and Control group (p<0.05) level. Hence hypothesis H3 is rejected.

CONCLUSION

The analysis of the findings indicated that, Life skill education package is effective to increase the knowledge and to change the attitude of the adolescents affected with HIV.The post-test was conducted on the study group shows that there is a difference in the knowledge and attitude as compared to pre test indicating that the Life skill education package is effective and there is a need for that. The results of the study will enable the health professionals to utilize the structured teaching programme to the adolescents in the community/college settings as an additional intervention in prevention of AIDS by improving the knowledge, change of attitude and behaviour in a positive direction. So Life skill education package is one of the effective method in imparting the knowledge, and changing the attitude of adolescents on AIDS . Therefore the researcher felt that the Life skill education package is effective and help to enhance the knowledge and change of attitude behaviour in a positive direction.

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IMPLICATIONS

As the saying goes “Prevention is better then cure” is very true in the prevention and control of HIV/AIDS. Prevention is the only weapon in the war against AIDS since there is no cure to it. The health professionals play a key role specially, the nurses in educating the public in general and youths in particular on AIDS and its prevention. The findings of this study have implications in various areas of nursing namely: nursing practice, nursing education nursing administration and nursing research. The findings of this study have implications in various areas of nursing namely: nursing practice, nursing education nursing administration and nursing research.

Implications for nursing practice

Nurses play an important role in the prevention of HIV/AIDS among adolescents in various settings. The findings of the study shows that the structured teaching programme on AIDS and its prevention is effective in gaining knowledge and change of attitude in a positive direction.

If the nurses have a thorough knowledge and awareness regarding AIDS and its prevention, they can incorporate this in to their practice while providing high quality care in cost effective way and make these health services accessible to under served population. more than that the nurses are able to become efficient health team members and get automomy, authority and independency in practice.

In the area of nursing practice, nurses should help the teachers, parents, students and the general public to express, recognize and develop positive attitude towards people living with HIV/AIDS.

Nurses,

- should involve teachers, parents, students and General public in regular teaching programme.
- should organize, conduct and evaluate the structured teaching programme on AIDS and its prevention .

Implications for nursing education

Education is a key component to update and improve the knowledge of an individual, the family and the community at large. Education in nursing has a vital role to play. Since today's nursing students are tomorrow's staff nurses, educators, administrators and supervisors, nursing educators should prepare them not only to care for the patients with HIV/AIDS but also to handle the complex and changing needs of the society. The study stresses the need for the assessment of knowledge, attitude of adolescents affected with HIV and to evaluate the effectiveness of Life skill education package on AIDS . In view to prevent the HIV/AIDS among adolescents, the nurse educators should motivate the student nurses to assess the learning needs of adolescents on AIDS and its prevention and to organize the programmes in this direction. The post graduate courses should prepare clinical nurse specialist who can take care of the issues related to HIV/AIDS prevention. They can serve as resource persons for other nurses and nursing students working with people having HIV/AIDS. Plan, organize and conduct programmes for the nurses, community health workers and others concerned with health team, so that they can update their knowledge and abilities to deal with the impact of HIV/AIDS on quality of life of people affected by HIV/AIDS and to adopt effective coping strategies.

Implications for nursing administration

Nursing administrators are the key persons to plan, organize and execute the curriculum to nursing students. They should take initiative and motivate the teachers, parents, students and general public in health education programmes and other health related activities. Nursing administrators have a responsibility to provide an opportunities for the staff development activities.

The nurse administrator should look after the special units and provide adequate support with money, material and man power for conducting teaching programmes and developing teaching material or self instructional module regarding management and prevention of HIV/AIDS. Nurse administrators should influence policy makers to provide better facilities for people with HIV/AIDS in terms of materials, prospective job placement, position, promotion and financial security. They should also arrange camps, career day programme and campus selection etc., for people living with HIV/AIDS.

Implications for nursing research

This topic has great relevance to the present day complexities of the health care delivery. The review of literature revealed that there is dearth of literature related to the various findings of the study and it was found that very few Indian studies being done to assess the knowledge, and attitude, and the effectiveness of Life skill education package on AIDS among adolescents affected with HIV . Hence the findings of his study can motivate nurse researchers to conduct more studies related to Life skill education package on AIDS.

LIMITATIONS

Since the adolescents were scattered in different areas the researcher had a lot of difficulty in gathering the adolescents in one place to conduct the study.

RECOMMENDATIONS

The following further studies are directed on the basis of the present study.

- A similar study can be replicated on a adolescents with different demographic characteristics and with different techniques.
- A comparative study can be done on rural and urban community, literate and illiterate population
- A longitudinal study can be conducted to determine the long term effectiveness of Life skill education package.

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ANNEXURE- I

LETTER SEEKING PERMISSION TO CONDUCT A RESEARCH STUDY

St. XAVIER'S CATHOLIC COLLEGE OF NURSING

Chunkankadai, Nagercoil,
Kanyakumari District,
Tamil Nadu - 629 003.

Tel : College : 04651 - 231740
Cell : 9840307884
Fax : 04651 - 230914
E-mail : xaviers_nursing@yahoo.com
reenaevancy@yahoo.com
Website : www.xaviersnsg.edu.in

Dr. A. REENA EVENCY, M.Sc. (N)., Ph.D.,
Principal

06.05.2013

To

The director
The Salvation Army,
Community Health Department ,
Nagercoil.

Respected Madam/ Sir,

Mrs.J.S.SeleenaJones, is a student of M. Sc., Nursing programme from the Clinical Speciality, Child Health Nursing in our college. She is conducting a study on **"An experimental study to evaluate the effectiveness of Life skill education package upon knowledge and attitude of HIV among adolescents in selected settings , kanyakumari district".**

This is for the research project to be submitted to the Tamilnadu Dr. M.G.R Medical University in Partial fulfillment of university requirement for the award of M.Sc., Nursing Degree and will be beneficial in understanding and improving the health of the babies.

As a part of her study she needs to evaluate the effectiveness of life skill education package on knowledge and attitude of HIV among HIV affected adolescents. So permission may kindly be granted for her to conduct the study at your esteemed Hospital. She will abide by the rules and regulations of your Hospital.

Thanking you

Yours faithfully,

PRINCIPAL
ST. XAVIER'S CATHOLIC COLLEGE OF NURSING
CHUNKANKADAI
NAGERCOIL - 629 003
K. K. DIST.

ANNEXURE -II

LETTER GRANTING PERMISSION TO CONDUCT A RESEARCH STUDY

THE SALVATION ARMY COMMUNITY HEALTH
AND DEVELOPMENT PROGRAMME
Catherine Booth Hospital Campus
Nagercoil - 629 001. Tamil Nadu, India

WILLIAM BOOTH
Founder

LINDA BOND
General

COMMISSIONER M.C. JAMES
Territorial Commander

"The Salvation Army is a Christian Church and a Charitable organization"

June 10, 2013

TO WHOM SO EVER IT MAY CONCERN

This is to certify that Mrs. J.S. Seleena Jones, M.Sc (N) II year student of St. Xavier's Catholic College of Nursing, can have her study of evaluating the effectiveness of life skill education package on knowledge and attitude of AIDS among adolescents with HIV in our institution.

We assure you that we will extend our full support to complete her project.

G. BENJAMIN DHAYA, MBA., M.S.W
Director
The Salvation Army Community Health and Development Programme

THE SALVATION ARMY COMMUNITY HEALTH & DEVELOPMENT PROGRAMME
NAGERCOIL - 629 001
KANYAKUMARI DIST.
INDIA
Ph: 04652 - 15
CBH CAMPUS

ANNEXURE-III

LETTER SEEKING EXPERTS OPINION FOR THE VALIDITY OF THE TOOL

From

J.S.Seleena Jones,
M.Sc., Nursing II year,
St. Xavier's Catholic college Of Nursing,
Chunkankadai**.**

To

Dr. Sashya Jeyaharan, MD, DCH,
Director and senior consultant,
Jeyaharan Memorial Hospital,
Nagercoil.

Respected Sir/ Madam,

Sub: Requisition to expert opinion and suggestion for the content validity.

I, J.S.Seleena Jones, M.Sc., Nursing II year student of St.Xavier's Catholic College Of Nursing, Chunkankadai, have selected the following topic**, "An study study to evaluate the effectiveness of Life skill education package upon knowledge and attitude of HIV among adolescents in selected settings , kanyakumari district.**"for my dissertation to be submitted to Tamilnadu Dr. M.G.R. Medical University in the partial fulfillment of the requirement for award of Master of science in Nursing.

I request you to go through the items and give your valuable suggestions and opinions to develop the content validity of the tool. Kindly suggest modifications, addition and deletions if any in the remarks column.

Thanking You,

Place: Chunkankadai. **Yours sincerely,**

Date: **J.S.Seleena Jones.**

ENLOSURES:

1. Problem statement, objectives, and hypothesis of the study.
2. Demographic profile.
3. Observational Rating scale.
4. Evaluation proforma

ANNEXURE-IV

EVALUATION CRITERIA CHECK LIST FOR TOOL VALIDATION

INSTRUCTIONS:

The expert is requested to go through the following criteria for evaluation. Three columns are given for responses and a column for remarks. Kindly please tick mark (✓) in the appropriate columns and give remarks. Interpretation column:

Column I – meets the criteria.

Column II - Partially meets the criteria.

Column III – does not meet the criteria.

S. NO	CRITERIA	1	2	3	REMARKS
1.	Scoring -adequacy. -clarity. -simplicity.				
2.	Content -logical sequence. -adequacy. -relevance.				
3.	Language -Appropriate. -clarity. -simplicity.				
4.	Practicability -easy to score. -precise. -utility.				

Signature: **Any other suggestion:**

Name:
Designation:

CRITERIA CHECKLIST FOR VALIDATION OF THE TOOL

INSTRUCTION:

Kindly review the Questionnaire and give your suggestions regarding the accuracy, relevance and appropriateness of the content. Kindly place a tick mark (✓) against specific columns.

Validation Of Demographic variables.

Item	Very relevant	Relevant	Need for modification	Not relevant	Remarks
1.					
2.					
3.					
4.					
5.					
6.					
7.					

ANNEXURE-V

LIST OF EXPERTS VALIDATED THE TOOL

1. **Dr. MuthuRamasubramanian, MBBS, M.D(Paediatrics)**
   Government medical college Hospital,
   Asaripallam,
   Nagercoil.

2. **Dr. SashyaJeyaharan, MD, DCH,**
   Director and Senior Consultant,
   Jeyaharan Memorial Hospital,
   Nagercoil.

3. **Dr. Judie, M.Sc.(N) P.hd (N),**
   Dean
   S.R.M. College of Nursing
   Chennai.

4. **Mrs.D. Prema Latha, M.Sc., (N)**
   Assistant Professor,
   Christian College of Nursing,
   Neyyoor.

5. **Mrs.Malhija, M.sc., (N)**
   Assistant professor,
   Christian College of Nursing,
   Neyyoor.

ANNEXURE-VI

INFORMED CONSENT

I _____ willing to participate in the study to evaluate the effectiveness of Life skill education package, without any compulsion. I came to know through the researcher that the massages are harmless and easy to follow.

Yours Sincerely,

ANNEXURE-VII

CERTIFICATE OF ENGLISH EDITING

MRS.M.RAGUBATHY,M.A(ENG), M.A.(LING), M.PHIL,
P.G.ASSISTANT (ENGLISH),
G.H.S.S, THITTUVILAI.
MOBILE: 9843707169

DATE: 31/1/2014

TO WHOMSOEVER IT MAY CONCERN

Certified that the dissertation paper titled **"An experimental study to evaluate the effectiveness of Life skill education package upon knowledge and attitude of HIV among adolescents in selected settings , kanyakumari district." by Mrs. J.S.Seleena Jones**, has been checked for the accuracy and correctness of English language usage and that the language used in the tool is lucid, unambiguous free of grammatical or spelling errors and apt for the purpose.

Mrs. M. Ragubathy M.A., B.Ed., M.Phil.
P.G. Asst. (English)
G.H.S.S. Thittuvilai,
K.K.Dist.

ANNEXURE-VIII

CERTIFICATE OF TAMIL EDITING

MRS. B. SANTHI,M.A,B.ED,M.PHIL
B.T ASSISTANT (TAMIL),
CONCORDIA HIGHER SECONDARY SCHOOL,
POOTETTI.
MOBILE: 9940845487

DATE. 27/5/13

TO WHOMSOEVER IT MAY CONCERN

Certified that the dissertation paper titled **"An experimental study to evaluate the effectiveness of Life skill education package upon knowledge and attitude of HIV among adolescents in selected settings , kanyakumari district." by Mrs. J.S.Seleena Jones**, has been checked for the accuracy and correctness of Tamil language usage and that the language used in the tool is lucid, unambiguous free of grammatical or spelling errors and apt for the purpose.

B Santhi.

பா.சாந்தி, M.A., B.Ed., M.Phil.,
தமிழ் பண்டிதர்,
கன்கார்டியா மேல்நிலைப் பள்ளி,
பூட்டேற்றி – 629 157,
கன்னியாகுமரி மாவட்டம்.

ANNEXURE- IX

CERTIFICATE OF STATISTICAL ANALYSIS

TO WHOMSOEVER IT MAY CONCERN

Certified that the dissertation paper titled "**A quasi experimental study to evaluate the effectiveness of Life skill education package on knowledge and attitude of adolescents with HIV in selected settings , Kanyakumari district**" done by Mrs. J.S. Seleena Jones has been checked for accuracy in statistical analysis and interpretation and was apt for the purpose.

Signature

Dr. G. IMMANUEL
Assistant Professor
Centre for Marine Science & Technology
Manonmaniam Sundaranar University
Rajakkamangalam - 629 502
K. K. District, Tamilnadu, India

ANNEXURE- X

TOOL FOR DATA COLLECTION

The tool used in this study has 2 parts.

Section : A

Demographic variables such as age, sex, economic status, educational status, religion, type of family, living area.

Section : B

Structured questionnaire to collect data regarding knowledge and attitude.

SECTION : A

DEMOGRAPHIC VARIABLES

I) AGE

a} 13 - 15 Years

b} 16 - 18 Years

II} SEX

a} Male

b} Female

III} ECONOMIC STATUS

a} Below Rs..5000

b} Rs.5001 – Rs.10000

c} Above Rs.10001

IV}EDUCATIONAL STATUS

a} 8^{th} Std – 10^{th} Std

b} 10^{th} Std -12^{th} Std

c} School Dropouts

V) RELIGION

a) Hindu

b} Christian

c) Muslim

d) Others

VI) TYPE OF FAMILY

a)Nuclear Family

b) Joint Family

c) Broken Family

VII) LIVING AREA

a)Urban

b)Rural

c)Semi Urban

SECTION: B

Please read the questions below and give your answers in the space provided

I : AIDS and its transmission, clinical manifestation, diagnosis,prevention,nutrition, network services.

1. What does the acronym HIV stands for?

a) Human insufficiency virus

b) Human immune deficiency virus

c) Human immobilization virus

2) What does the acronym AIDS stands for?

a) Active immunological disease syndrome

b) Acquired immune deficiency syndrome

c) Acquired immunological derivative syndrome

3) What is the main means of HIV transmission worldwide?

a) Unprotected hetero sexual route

b) Homosexual sex

c) Intravenous drug use

d) Mother to child transmission

4) HIV cannot be transmitted through

a) Breast milk

b) Insect bite

c) Semen

d) Sharing needles

5) The below body fluids when infected may transmit HIV except

a) Vaginal fluids

b)Cerebrospinal fluid

c) Blood

d) Sweat

6) What are the typical symptom of AIDS in the initial stage?

a) Fever, sore throat, blotchy rash, swollen glands

b) Fever, aches, pain

c) Sore throat, skin problems

d) Herpes Zooster

7) What is the end stage of HIV infection?

a) Death

b) AIDS

c) Tuberculosis

d)Hepatitis

8) When it is diagnosed as AIDS?

a) CD 4 count< 350 cells/mm3

b) CD 4 count<200 cells/mm3

c) CD 4 count <500 cells/mm3

9) HIV can be confirmed by the following diagnostic test

a) Western blot

b) ELISA

c) Coomb's test

d) Hemoglobin

10) The person infected with HIV should take more

a) Starchy foods

b) Fruits

c) Meat

d) Green leafy vegetables

11) Spread of HIV by sexual transmission can be prevented by

a) Abstinence

b) Practicing mutual monogamy with an uninfected partner

c) Correct use of condoms

12) The new trends in treating HIV/AIDS?

a) Stem cell therapy

b) Blood transfusion

c) ART

d) Bone marrow transplantation

13) Which drug is given for a HIV positive mother during delivery?

a) Nevirapine

b) Abacavir

c) Zidovidine

d}Lamividine

14) Legal AID clinic in Tamilnadu is first opened in

a) Tirurnelveli

b) Nammakkal

c) Kanyakumari

d)Chennai.

15) Legal AID services are supported by

a) WHO

b) UNDP

c) UNICEF

d) UNESCO

ATTITUDE SCALE

Sl.NO	ITEM	STRONGLY DISAGREE	DIS AGREE	UNCERTAIN	AGREE	STRONGLY AGREE
1.	Sweat is considered at risk for HIV					
2.	Most people who have AIDS deserve what they get					
3.	I think people with AIDS have the right to have the same quality of care as any other patient					
4.	I would do everything i could support people like me					
5.	HIV enters in to the body when proper nutritious diet is not taken					
6.	I would worried of my child getting AIDS if i get married.					
7.	Women are at greater risk of acquiring HIV through sex.					
8.	If a women is HIV positive all her babies will be HIV infected because they share the same blood.					
9.	If both parents are HIV positive using condoms during sexual intercourse is not necessary .					
10.	Sex workers are the only women who have to worry about getting HIV.					

11.	Men who have to worry about getting HIV HIV/AIDS spreads due to immoral behaviour					
12.	Men who go to sex workers or use drugs are the only person who get HIV.					
13.	People living with HIV should have a right to decidewho should know about their status.					
14.	People with HIV should be allowed to get married.					
15.	·HIV positive women should not get pregnant					

பிரிவு: அ

மக்கள்தொகை மாறிகள்

I) வயது
அ} 13 - 15 வயது
ஆ} 16 - 18 வயது

II} பாலினம்
அ} ஆண்
ஆ} பெண்

III} பொருளாதாரநிலை
அ} ரூ.5000-க்குகீழே
ஆ} ரூ.5001 –ரூ.10000
இ} ரூ.10001 க்குமேல்

IV} கல்விதகுதி
அ} 8-வதுவகுப்பு – 10வதுவகுப்பு
ஆ} 10- வதுவகுப்பு -12 வதுவகுப்பு
இ}பள்ளிஇடைநிற்றல்

V) மதம்
அ) இந்து
ஆ} கிறிஸ்துவர்
இ) முஸ்லீம்
ஈ) மற்றவர்கள்

VI) குடும்பவகை
அ)தனிக்குடும்பம்
ஆ)கூட்டுகுடும்பம்
இ)சிதைவுபட்டகுடும்பம்

VII) வாழ்க்கைபகுதி
அ)நகர்ப்புறபகுதி
ஆ)கிராமப்புறபகுதி
இ)அரைநகர்ப்புறபகுதி

பிரிவு - ஆ

கீழேகுறிப்பிட்டுள்ளவினாக்களைப் படித்துஅதற்குரியகட்டத்தில் விடையளிக்கவும்.

எய்ட்ஸும் பரவும் முறைகளும், நோயின் தன்மைகள், கண்டறியும் முறைகள், தடுப்பு முறைகள், ஊட்டச்சத்துக்கள், கூட்டமைப்பு சேவைகள்.

1. எச்.ஐ.வி. என்றால் என்ன?

அ) மனிதபற்றாக்குறைவைரஸ்

ஆ) மனிதனின் எதிர்ப்பாற்றலைக் குறைக்கும் வைரஸ்

இ) மனிதனைநகர்த்தமுடியாதபடிசெய்யும் வைரஸ்

2. எய்ட்ஸ் என்றால் என்ன?

அ) தீவிரநோய் எதிர்ப்புத்திறன் காரணி

ஆ) பெறப்பட்டநோய் எதர்ப்புத்திறன் குறைபாட்டுக்காரணி

இ) பெறப்பட்டநோய் எதிர்ப்புத்திறன் பெறும் காரணி

3. உலகம் முழுவதும் எச்.ஐ.வி. பரவுவதன் மூலக்காரணம் என்ன?

அ) பாதுகாப்பற்றஉடலுறவு

ஆ) ஓரினச்சேர்க்கை

இ) இரத்தநாளம் வழியாகசெலுத்தப்படும் மருந்து மூலமாக.

ஈ) தாயிடமிருந்துகுழந்தைக்குக் கடத்தப்படுவதினால்

4. எச்.ஐ.வி இவ்வாறு பரவுவதில்லை

அ) தாய்ப்பால்

ஆ) பூச்சிக்கடி

இ) விந்துதிரவம்

ஈ) ஊசிகளைப் பகிர்ந்துகொள்ளுதல்

5. கீழேகொடுக்கப்பட்டஉடல் திரவங்களில் ஒன்றைத் தவிரமற்றவைகள் மூலம் எச்.ஐ.வி. பரவும்

அ) யோனித்திரவம்

ஆ) மூளை தண்டுவடதிரவம்

இ) இரத்தம்

ஈ) வியர்வை

6. எய்ட்ஸ்-ன் முதல் நிலையின் அறிகுறிகள் எவை?

அ) காய்ச்சல், தொண்டைசுழற்சிநோய், தோல் நோய், சுரப்பிகளில் வீக்கம்

ஆ) காய்ச்சல், உடல்வலி.

இ) தொண்டைசுழற்சிநோய், தோல் வியாதிகள்

ஈ) தட்டம்மை

7. எச்.ஐ.விநோயின் இறுதிநிலை

அ) இறப்பு

ஆ) எய்ட்ஸ்

இ) காசநோய்

ஈ) மஞ்சள் காமாலை

8. எப்பொழுதுஎய்ட்ஸ் என்றுஉறுதிசெய்யப்படுகிறது?

அ) சி.டி. 4 அணுக்களின் எண்ணிக்கை< 350 அணு/mm3

ஆ) சி.டி. 4 அணுக்களின் எண்ணிக்கை< 200 அணு/ mm3

இ) சி.டி. 4 அணுக்களின் எண்ணிக்கை< 500 அணு/mm3

9. எச்.ஐ.வி. எந்தப் பரிசோதனையின் மூலம் உறுதிசெய்யப்படுகிறது.?

அ) வெஸ்ட்டர்ன் ப்ளாட்

ஆ) எலிசா

இ) கூம்ப்ஸ் சோதனை

ஈ) சிவப்பு இரத்தஅணுக்களில் உள்ளநிறமி.

10. எச்.ஐ.வி. பாதிக்கப்பட்டவர்கள் அதிகம் உட்கொள்ளவேண்டியஉணவு

அ) மாவுச் சத்துணவு

ஆ) பழவகைகள்

இ) இறைச்சி

ஈ) பச்சைக்கீரை, காய்கறிகள்.

11. உடலுறவு மூலம் எச்.ஐ.வி. பரவாமல் இவ்வாறுதவிர்க்கலாம்

அ) உடலுறவுகொள்ளாமல் தவிர்த்தல்

ஆ) கணவன் அல்லதுமனைவியிடம் மட்டும் உறவுவைத்துக் கொள்வது

இ) சரியானமுறையில் ஆணுறைபயன்படுத்துவது.

12. எச்.ஐ.வி. / எய்ட்ஸைக் குணப்படுத்ததற்போதுகையாளும் புதிய சிகிச்சைமுறை

அ) ஸ்டெம் செல் சிகிச்சை

ஆ) இரத்தப்பரிமாற்றம்

இ) வைரஸ்எதிர்ப்பு மருந்துசிகிச்சை

ஈ) எலும்பு மஜ்ஜை மாற்றுசிகிச்சை

13. கீழ்கண்டவைகளில் எந்தமருந்துபிரசவநேரத்தில் எச்.ஐ.வி-யால் பாதிக்கப்பட்டதாய்க்குகொடுக்கப்படுகின்றது.?

அ) நெவிரப்பின் இ) அபாகாவிர்

இ) சிடோவீடின் ஈ) லாமிவிடின்.

14. முறையானஎய்ட்ஸ் மருத்துவசிகிச்சைமையம் தமிழ்நாட்டில் முதலாவதாகநிறுவப்பட்டது.

அ) திருநெல்வேலி

ஆ) நாமக்கல்

இ) கன்னியாகுமரி

ஈ) சென்னை

15. சட்டப்படியானஎய்ட்ஸ் சேவைகளுக்குஉதவுவது

அ) உலகசுகாதாரநிறுவனம்

ஆ) ஐக்கியநாட்டுவளர்ச்சித் திட்டம்.

இ) ஐக்கியநாட்டுகுழந்தைகள் அவசரகாலநிதிநிறுவனம்

ஈ) ஐக்கியநாட்டுகல்விஅறிவியல் மற்றும் பண்பாட்டுஅமைப்பு.

கருத்துஅளவீடு

வ. எண்	பொருள்	உறுதியாகஏற்றுக் கொள்ளவில்லை	ஏற்றுக்கொள்ளவில்லை	கருத்துக்கூறஇயலவில்லை	ஏற்றுக் கொள்கிறேன்	உறுதியாக ஏற்றுக் கொள்கிறேன்
1.	வியர்வையினால் எச்.ஐ.வி. பரவும் என்று கருதப்படுகிறது.					
2.	பெரும்பாலான எய்ட்ஸ் நோயாளிகள் உரிய சிகிச்சை எடுத்துக் கொள்ளாமல் தங்களுக்குள் வைத்துக் கொள்கிறார்கள்.					
3.	எய்ட்ஸ் நோயாளிளுக்கும் இதர நோயாளிகளைப் போன்று சமமாகச் சிகிச்சை எடுத்துக் கொள்ளஉரிமை உள்ளது என்று நான் நினைக்கிறேன்.					
4.	என்னைப் போன்றபிற மக்களுக்குஎன்னால் இயன்ற உதவியைச் செய்வேன்.					
5.	நல்ல ஊட்டச்சத்துள்ள உணவுகளைஉண்ணாத காரணத்தினால் தான் எச்.ஐ.வி உடலுக்குள் ஊடுருவுகின்றது என்று நினைக்கின்றேன்.					
6.	நான் திருமணம் செய்தால் என் குழந்தையும் இதேநோயால் பாதிப்புக்குஉள்ளாகும் என்று கவலை கொள்கிறேன்.					
7.	உடலுறவால் ஏற்படும் எச்.ஐ.வி.ஆல் அதிகம் பாதிக்கப்படுபவர்கள் பெண்கள்.					
8.	எச்.ஐ.வி ஆல் பாதிக்கப்பட்ட பெண்களின் குந்தைகளும் அதேநோயால் பாதிக்கப் படுவார்கள். ஏனென்றால் அவர்கள் ஒரே இரத்தத்தைப் பகிர்ந்துகொள்ளுகிறார்கள்.					

9.	பெற்றோர் இருவரும் எச்.ஐ.வி – ஆல் பாதிக்கப்பட்டிருந்தால் உடலுறவின் போதுஆணுறைகளை உபயோகிக்க வேண்டிய தேவை இல்லை.					
10.	பெண்களில் பாலியல் தொழிலாளிகள் மட்டுமே எச்.ஐ.வி. பாதிப்பு பற்றி கவலைப்படவேண்டும்.					
11.	ஆண்களில் தங்கள் தவறான நடத்தை உடையவர்கள் எச்.ஐ.வி/எய்ட்ஸ் பற்றிகவலைப்படவேண்டும்.					
12.	ஆண்களில் பாலியல் தொழிலாளிகளை நாடுபவர்கள் மற்றும் போதை மருந்துக்கு அடிமையானவர்கள் மட்டுமே எச்.ஐ.வி பாதிப்புக்குஉள்ளாகிறார்கள்.					
13.	எச்.ஐ.வி ஆல் பாதிக்கப்பட்டவர்கள் தங்களின் உடல் நிலையைப் பற்றிஅறியஅவர்களுக்கு உரிமைஉண்டு.					
14.	எச்.ஐ.வி ஆல் பாதிக்கப்பட்டவர்கள் திருமணம் செய்துகொள்ள அனுமதிக்கப்படவேண்டும்.					
15.	எச்.ஐ.வி பாதிக்கப்பட்ட பெண்கள் கருத்தரிக்ககூடாது.					

ANNEXURE-XI

LIFE SKILL EDUCATION PACKAGE OF HIV / AIDS

Task -1

What is AIDS?

H.I.V is a virus. It is just like a organism that causes cold. But HIV is a different from that, as it destroys the immune itself.

What is immune system? How does it prevent us from other diseases and illness?

The immunity is strong so long as we are in good and sound health. But when we are affected by any disease we don't take proper food and rest sufficiently. As a result the strength of the immunity of our body decreases. By outward appearance, it is not possible to diagnose whether the person has been infected with HIV. HIV causes destruction to a human body just like the termites that destroy a house or a building gradually. The existence of termites in a building and what it does to the building may not be aware for years (just like HIV) But, one day or other, suddenly the entire building falls down and get destroyed when a strong storm blows. Can we guess what might be the reason for such a sudden destruction? Is it the storm or the termite?.... the termites! Similarly HIV destroys a human body.

Task:

Let two or three children stand in the middle of the children standing a circle. Paste a chart named the word 'immunity' on each child. Ask the children to act or dance according to the music played. Other children may stand as a circle round the 'immunity' with joining their hands. Their name is "T cells". These children protect the 'immunity' children as they dance. There are few children called micro organism causing certain diseases like cough, eczema, T.B and mumps etc. trying to invade into the circle. But the 'T' cell children refuse to allow the above germs to enter inside the circle as they are

strong. So the organisms go out dejected. Now a small boy named "HIV" tries to enter the circle. Infact,HIV is so strong it enter inside the circle. So the 'T' cells loses their strength and fall down. The HIV children who are in the middle also become weak, loses their strength & fall down. Further 'T' cell also loses their strength. (force of the dance decreases) or gets destroyed and they fall outside the circle.

Now the organisms of the infectious disease return and attack, the children who are in the center. They fall down.

Change:

As soon as the children in the center fall down, three children namely food, rest and pleasant feeling or ART come. The HIV children, who are in the middle dances slowly. The children at the centre feel better. If the disease attack again the 'T' cells would drive them away. As soon as the ART and the other come in, HIV losses its strength. But HIV does not leave the body.

Change:

To get the Co-operation from the children, make the children to stand like a statue, whenever the microorganism attacks.

Review:

Questions to be asked with the children

- ★ What did they see and learn about HIV infection?
- ★ Why women are more risk to get HIV infection?
- ★ Is it possible to diagnose on seeing a person whether he/she is infected with HIV?
- ★ What happens to the immune power of a person who has HIV infection?
- ★ Which causes death to a HIV/AIDs patient?
- ★ Co-relating the skills they have learned is to their life.

1. What do their friends and community members know about HIV?
2. Don't forget to ask, why does HIV infection affects on the women's side? This is a general research through questions. When the child demonstrate the skills it will help them to remember, what they have learned.

Task -2

HIV- infection (Portal of entry):

1) If HIV has to enter a human body there must be an entrance and a conveyor. Here conveyor denotes the oozes of water (fluid) in the body. (Explain through pictures)
2) Take a chart paper. In the half side of the paper, write, "infectious fluid and in the other half side write as non- infectious body fluid. In the first, part write the body specific fluids from ovary, semen, blood and also the other body fluids such as water, tear, sweat, urine and saliva.

★ Write the word 'Door' where it has been written as fluids that will transmit HIV when the door opens, then only the virus can enter inside the body.
★ Discuss and write that soft tissue or thin skin is seen over a cut, a scratch wound, sore and at the cervix, tip of penis, anus, mouth, eye and nose
★ Make the team understand how HIV spreads
★ Having oral sex, when there is a mouth ulcer vaginal sex, anal sex with a women.
★ Using the injection needle that was already used to an HIV patient, through tat-too and by using unsterilized medical instruments
★ From the mother to child (during delivery and Breast feeding
★ Blood transfusion (Blood which is not screened)

If the traineesdonot like to draw pictures, they may use printed picture and paste them wherever needed. This may help the children understand well and keep them in their memory.

This should be simpler and easier to the trainers to give sex and sexual training.

Task: 3

Stop! Think! Go!

1) Write ‘Stop’ in a red colour paper. This indicates that the risk of HIV is more. Then write ‘Think’ on an yellow paper. This indicates that there may be the danger of HIV. Again write ‘Go’ on a green paper. This denotes that there is no chance for the risk of ‘HIV’.
2) To identify the behaviour tell the children to stand under proper response. Ask them why the particular act is dangerous or not dangerous.

Sl.No	Example	Colour
1	Donating blood	Green
2	Oral sex without condom	Red
3	Taking food cooked by the HIV infected person	Green
4	Hugging – embracing	Green
5	No intercourse (This prevents HIV Infection – 100%	Green
6	Using Public Toilets	Green
7	Kissing	Yellow (if there is a wound in the mouth) Green (There is no wound in the mouth)
8	Anal sex without condom (There is a chance of the blood vessels to rupture)	Red (There is possibility of the entry of the organism through the thin blood vessels))
9	Sexual intercourse without using condom	Red
10	When there is a HIV infection, if the mother conceive	Yellow – When ART is given during pregnancy 2/3 of the infection
11	Mosquito biting	Green
12	Sharing needles	Red

13	Taking alcoholic drinks	Yellow
14	Using the condom each time properly	Green
15	Sexual act with different persons with or without using condom (above 14 years old)	Red
16	Sexual contact with sex workers one time without using condom	Red
17	Sexual act in between a man and woman only (a male sex and female sex)	Green

Review:

- ★ Did you get the answer immediately or they took time to think?
- ★ How did the others in the team answered?
- ★ How can the youngsters prevent HIV infection?
- ★ Have a discussion in your team about the green (colour) card particularly about the questions regarding the sexual intercourse? Also discuss about non- sexual contact, being loyal and also about using condom.

Task -4

Script for Attitude Questions

A newly wedded couple is living in a house. The husband is an employee, going out for work. The wife is looking after the home affairs, on the day (occasion) the husband has gone for work. The wife is at home. At this time she receives a phone call from her friend.

Swetha : HaiRevathi, How are you?

Revathi : Fine, How are you?

Swetha : I'am also fine

Revathi : I saw your (husband) hubby at ThambaramSanitoriam Hospital

Swetha : At ThambaramSanitoriam Hospital? Can't be, no chance. (with a doubt)

Revathi : No, I am sure. I did see him**.**

Swetha : Is it? He might have gone there in connection with his job. He might be there for taking an order.

Revathi : OK, I think ,he has come. I'll talk to you later?

Husband comes

Sekhar : Hai what are you doing there, Swetha?

Swetha : I was speaking with a friend. OK, take a bath and let us dine

Sekhar : Coughing…. I don't want any thingswetha

Swetha : How may days I have been asking you toconsult a doctor. You never heard to me?

Sekhar : Sorry ma, certainly I'II go tomorrow. Give me a cup of milk. That will do.

Swetha : Sure (OK)

Sekhar sits on the bed after changing his dress. He takes a tablet seeing at the door if anyone notices him. Mean while his wife Revathi comes in (notices and enters the room)

Swetha: (Angrily) tell me what are you taking now? What did you put into your mouth? Come on tell me?

Sekhar: That's ……that's……a tablet……

Swetha: For what……is it for cough? But when I asked, you simply said that you did not go to the doctor.

Sekhar: Now …..I just bought it from a medical store

Swetha: OK, but why did you hide it from me?

Sekha: That's ……..if you know this, you would get angry with me. You have told me not to buy any medicine form the medical store. That's why I had to hide it from you.

Swetha: You are talking lies too much and also hiding so many things from me. She goes out

Sekhar had slept but swetha was unable to sleep, she gets up from her cot and begins to check her husband's bag. She takes out a tablet from the bag. It's a 'ZIDOVIR' tablet. She calls their family doctor and enquires about that tablet. She is shocked to hear that that tablet 'ZIDOVIR" is the tablet for 'AIDS'. She begins to sob. She writes a letter and puts it on the cot. Then she leaves the house.

In the letter she has stated,

"You had cheated me. My entire life had been spoiled. You are an AIDS patient. Don't try to contact me".

Sekhar wakes up in the morning and looks for his wife. Finds Swetha's letter and goes through it. He startles and sits holding his head.

At swetha's house:

Swetha's mother : What! Swetha, you have come without any intimation, Moreover you alone!.

Swetha : Mummy! Don't ask me anything. Whatever it may be, we shall talk later.

Swetha's mother : Are you going to tell me or not?

Swetha : Mummy, Im not going to live with that man. He is an AIDS patient.

Hearing this, mother shows no shock and says to swetha. "Your husband is not the AIDS patient. It's your dad. Two months back when it was diagnosed that your father had

been infected with AIDS. Your husband was the person who took him to the hospital and helped him getting necessary medical treatments ,still he buys tablets for your father and helps him a lot.

At sekhar's house:

Swetha : Kindly excuse me. I had mistaken you. Really sorry.

Sekhar : I was shocked when I went through your letter, Why do you get shocked when it is AIDS? It is just an infection like sputum and fever etc caused by an organism. Its ok. Come on! lets got to the doctor and clear all our doubts about AIDS.

Now the three, Swetha's mother, Swetha and Sekhar goes to the doctor.

Sekhar : Doctor we have a few doubt about AIDS. We have come to you to clear the doubts.

Doctor : O.K. with pleasure come on tell me all your doubts

Swetha : Is it true that only the persons who have sexual contact with prostitutes are infected by AIDS?

Doctor : No. ma what you are thinking is wrong. AIDs occurs not only to the persons who has sexual act with harlots. HIV is the virus which causes AIDs infection. AIDS (spreads) under the following reasons and circumstances.

1. When having sexual act with the persons who have AIDS infection.
2. To the child that is fed with breast milk of the mother who has AIDS infection
3. When one takes injection with the same needle that was already used to inject an AIDS patient.
4. When one gets blood donation from an AIDS infected person so, it's a false impression that the person who had sexual act with his/her opposite sex alone gets infected with AIDS.

Swetha : Could you please tell us the ways by which AIDS is spread and by which it is not spread?

Doctor : I had already explained you the ways by which AIDS is spread. The following factorsdo not spread AIDS. They are: sweating, tear, spinal fluid, urine and saliva of a person infected with AIDS and also using things used by such person.

Swetha: If so, AIDS will not spread through the sweating tear or saliva of an AIDS patient.Will it? who are the persons affected much by the AIDS?

Doctor : IT is women! Women alone get much infected with AIDS.

Swetha : What is the difference between AIDS and HIV Doctor?

Doctor : At first HIV virus infects one's body and it develops to the stage of AIDS. That is, the final stage of HIV is AIDS.

Swetha : Doctor can the persons who have been infected with AIDS get married? Can they have babies?

Doctor : Why can't? Certainly they can get married and can have babies because the male's sperm does not have HIV virus. Similarly, the baby in the womb of her mother gets infected only when the mother has got any other infections in the placenta or blood oozing in her stomach because of any reasons.

Sekhar: What are the rights and obligations of HIV infected Patient?

Doctor : HIV affected patients have the right to know about the health condition of his / her body. They should be allowed to get married.

Swetha: If both the husband and the wife are HIV affected patients do they need to use condom?

Doctor : Certainly! they must use condom

Swetha : What are the ways to prevent HIV infection Doctor?

Doctor : Safe sexual contact, used the screened blood. Not sharing the needles for injection, disciplinary life. These are the indispensable ways to prevent HIV infection.

Sekhar: All our doubts about the disease AIDS had been cleared. Thank you very much Doctor.

ANNEXURE-XII

FORMULAS USED FOR DATA ANALYSIS

DESCRIPTIVE STATISTICS

Mean $\bar{x} = \frac{\sum x}{N}$

Standard deviation $s = \sqrt{\frac{\sum(x-\bar{x})^2}{n-1}}$

INFERENTIAL STATISTICS

Independent 't' test $t = \left| x_1 - x_2 \right| \Big/ \sqrt{\frac{{s_1}^2}{n_1} + \frac{{s_2}^2}{n_2}}$

$$s = \sqrt{\frac{(n_1 - 1){s_1}^2 + (n_2 - 1){s_2}^2}{n_1 + n_2 - 2}}$$

Paired 't' test $t = \bar{d}\sqrt{n} \Big/ s$

$$s = \sqrt{\sum(d - \bar{d})^2 \Big/ n - 1}$$

Chi-Square test $x^2 = \sum \frac{(o-e)^2}{e}$

ANNEXURE-XII

PHOTOGRAPHS